Natura Wellness Clinic
Chiropractic • Naturopathy • Massage Therapy • Acupuncture
3885 Duke of York Blvd., Suite C211, Mississauga, ON L5B0E4 T: (905)276-6800 F: (905)276-6802 www.NaturaWellnessClinic.com

THERAPEUTIC MASSAGE HEALTH HISTORY FORM

It is important to fill out this form fully for you to receive massage therapy. All information disclosed is confidential except when required by law or your verbal & written consent is given. If there are any changes, please update with the therapist so they can help treat you safely.

PERSONAL INFORMATION

NAME: _____ D.O.B. (DD-MM-YY): ____-____-____ OCCUPATION: _____

ADDRESS: _____ CITY: _____ POSTAL CODE: _____

TEL: (Home) _____ (Work) _____ (Cell) _____

MAY WE CONTACT YOU BY PHONE/E-MAIL FOR UPDATES, EDUCATIONAL NEWS OR CLINIC PROMOTIONS? Y / N

E-MAIL ADDRESS: _____

PRIMARY COMPLAINT: _____

HOW IS YOUR GENERAL HEALTH STATUS: _____

HOW DID YOU HEAR ABOUT US? _____

HAVE YOU HAD: SWEDISH MASSAGE THERAPY BEFORE? **Yes / No**
HOT STONE MASSAGE THERAPY BEFORE? **Yes / No**

MEDICAL INFORMATION

Please indicate conditions you're presently experiencing or have experienced in the past & state the date of onset.

RESPIRATORY CONDITIONS: Y / N
Chronic cough ___ DATE: _____
Shortness of breath ___ DATE: _____
Bronchitis ___ DATE: _____
Asthma ___ DATE: _____
Emphysema ___ DATE: _____

CARDIOVASCULAR CONDITIONS: Y / N
High Blood Pressure ___ DATE: _____
Low Blood Pressure ___ DATE: _____
Heart Failure (CCHF) ___ DATE: _____
Heart Attack ___ DATE: _____
Stroke/CVA ___ DATE: _____
Pacemaker or similar device ___ DATE: _____
Heart Disease ___ DATE: _____
Phlebitis / Varicose Veins ___ DATE: _____

WOMEN: Pregnant ____ DUE: _____ Other: _____

OTHER MEDICAL / GYNEACOLOGICAL CONDITIONS: Y / N Onset: _____
Please Specify: _____
_____

INFECTIONS: Y / N
Skin Conditions ___ DATE: _____
Hepatitis ___ DATE: _____
TB ___ DATE: _____
HIV ___ DATE: _____

SKIN CONDITIONS? Y / N
Acne ___ DATE: _____
Dermatitis ___ DATE: _____
Skin Cancers ___ DATE: _____
Skin Lesions ___ DATE: _____
Eczema ___ DATE: _____
Psoriasis ___ DATE: _____
Rosacea ___ DATE: _____
Other: _____ DATE: _____

SKIN TYPE: Dry ___ Combination ___ Normal ___ Dehydrated ___ Oily ___ Mature ___ Porous ___

ALLERGIES: Y / N
Cosmetic Allergy/Perfume ___ DATE: _____
Natural Plant Minerals ___ DATE: _____
Essential Oils or Synthetics ___ DATE: _____
Other: _____ DATE: _____

FOOT CONDITIONS: Y / N
DATE: _____
Please Specify: _____
_____
_____

OTHER CONDITIONS: Y / N
Cancer ___ DATE: _____
Diabetes & Type ___ DATE: _____
Arthritis ___ DATE: _____
Epilepsy ___ DATE: _____
Loss of Sensation ___ DATE: _____
Hearing Problems ___ DATE: _____
Vision Problems ___ DATE: _____
Osteoporosis ___ DATE: _____

FAMILY HISTORY OF ANY CONDITIONS?: Y / N *Please Specify:* _____

ANY PRESENCE OF **INTERNAL PINS, WIRES, ARTIFICIAL JOINTS, SPECIAL EQUIPMENT**? Y / N

Please Specify (what & where): _____ DATE: _____

ANY **INJURIES**: (NATURE) _____ DATE: _____

ANY **SURGERIES**: (NATURE) _____ DATE: _____

CURRENT MEDICATIONS: _____ DATE: _____

- Conditions it treats: _____

PRIMARY MEDICAL DOCTOR: _____ TEL: _____

Address: _____

- IS THIS THE PHYSICIAN THAT REFERRED YOU TO US OR FOR MASSAGE THERAPY? **Y / N**

ARE YOU **CURRENTLY BEING TREATED BY ANOTHER HEALTH CARE PROFESSIONAL**? **Y / N**

If Yes: Type of Treatment: _____ Condition being treated: _____

Since When? (Date): _____ Feedback: _____

- IS THIS THE FACILITY THAT REFERRED YOU TO US OR FOR MASSAGE THERAPY?: **Y / N**

IS THERE ANYTHING ELSE YOU WOULD LIKE TO TELL US?

_____

I HEREBY CERTIFY THAT THE INFORMATION PROVIDED ON THIS FORM IS ACCURATE TO THE BEST OF MY KNOWLEDGE AND UNDERSTAND THAT IT IS MY RESPONSIBILITY TO INFORM MY REGISTERED MASSAGE THERAPIST OF ANY CHANGES IN MY HEALTH. I AGREE TO ALLOW THE PHYSICIANS WORKING WITHIN NATURA WELLNESS CLINIC TO EVALUATE MY FILES FOR FURTHER ASSESSMENT (IF NEEDED) TO HELP TREAT ME SAFELY.

CLIENT NAME: _____ **DATE:** _____

CLIENT'S SIGNATURE: _____

IF NEEDED: **SDM NAME:** _____ **DATE:** _____

RELATIONSHIP TO CLIENT: _____ **SDM SIGNATURE:** _____

YEARLY UPDATE:

PRIMARY COMPLAINT: _____ CLIENT'S SIGNATURE: _____ DATE: _____

PRIMARY COMPLAINT: _____ CLIENT'S SIGNATURE: _____ DATE: _____

PRIMARY COMPLAINT: _____ CLIENT'S SIGNATURE: _____ DATE: _____