

Last Name: _____

First Name: _____

Date of Birth: _____

Email: _____

Home Phone: _____ Cell Phone: _____ Work Phone: _____

Please Note: We will be sending you email reminders for your upcoming appointments.

Address: _____

City: _____ Province: _____ Postal Code: _____

Occupation: _____ Employer: _____

Emergency Contact: _____ Phone: _____

Family Physician: _____

Insurance Provider: _____

Insurance Policy #: _____ Group / ID #: _____

Policy holder: _____ Relation: _____

How were you referred to Elite?

Doctor (name & clinic): _____ Another client/friend (name): _____

Website Social Media Advertisement Event Hospital Gym Other _____

Please answer all questions to the best of your ability as they will be used to help plan a safe & effective treatment plan.

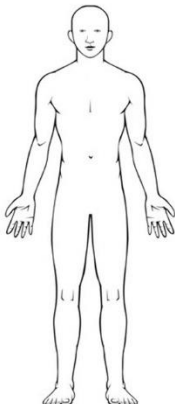
Have you ever received a professional massage? Yes No Last Massage? _____

Hobbies / recreational activities? _____

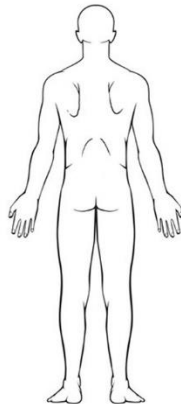
What are your main concerns / problem areas? _____

Feel free to draw your problem areas on the outlines below:

FRONT



BACK



LEFT



RIGHT



Are you under medical supervision? Please specify: _____

Do you regularly see: Physiotherapist Mental Health Professional Other: _____

Please list all prescription & other medication & reason for use: _____

Any major accidents / injuries / surgeries? Include date: _____

Females - Are you pregnant? No Yes – How far along? _____

Please list any and all allergies _____

Please indicate if you have any of the following, and whether you presently have the condition or have had it in the past:

Past / Present

- / Contagious Disease
- / Arthritis / Rheumatoid Arthritis
- / Circulatory Problems
- / High / Low Blood Pressure
- / Heart Condition
- / Kidney Disease
- / Respiratory Condition
- / Diabetes
- / Cancer / Tumors
- / Multiple Sclerosis
- / Fibromyalgia
- / Skin Condition
- / Anxiety / Depression
- / Frequent Infections / Flu
- / Carpal Tunnel Syndrome

Past / Present

- / TMJ / Jaw Pain
- / Whiplash
- / Sprains / Strains
- / Subluxations / Dislocations
- / Tendonitis
- / Muscle Cramps / Spasms
- / Headaches / Migraines
- / Bruise Easily
- / Vision / Hearing Problems
- / Pins / Artificial Joints
- / Plantar Warts
- / Osteoporosis
- / Numbness / Tingling
- / Pinched Nerve
- / Other: _____

I understand that I need to give 24 hours' notice if I wish to change or cancel my appointment. Same day cancellations and missed appointments will result in full payment of said appointment, due at my next treatment. Due to sensitivities, I will refrain from using perfumes and colognes. If I am under the influence of alcohol or illicit drugs, the treatment will be terminated and I will be required to pay the full treatment price. I agree to fully communicate with my therapist during the treatment regarding pressure, comfort, etc. so that the pressure / strokes used may be adjusted.

I, _____, understand and agree that the above information is accurate and correct, that I understand the above paragraph, and that I give my consent for the massage treatments. I understand that I must communicate to my therapist any and all health information pertaining to the massage treatment so the highest standard of safety can be obtained. I will also keep the therapist updated as to any health changes. As in all health care, I understand there are risks to massage therapy and that the massage therapist is in no way responsible for problems that may occur to me during or after the treatment (headache, bruising, soreness, etc.). Treatment results will vary depending on the individual and the severity of their condition. I understand that massage therapy is a therapeutic health aide and is in no way sexual in nature.

Note: In accordance with the Personal Health Information Act (PHIA), we endeavor to protect the privacy of our clients. Please be aware, we do not disclose patient information over the phone.

Signature: _____

Date: _____