ELITE
SPORTS INJURY

# Massage Therapy Health History Form

*Client Information*

**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____________

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

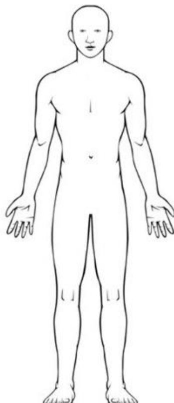
**Have you ever received a professional massage?** ☐ Yes ☐ No Last Massage? ________________

**Hobbies / recreational activities?** ____________________________________

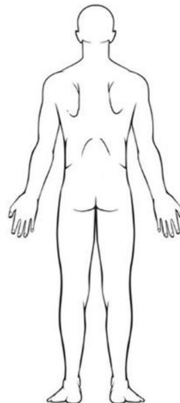
**What are your main concerns / problem areas?** ______________________________

**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** ______________________________________________

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**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 nor provide any information about appointments without their express consent.**

**Signature:** ______________________________ **Date:** ____________________