Hillhurst Massage
Therapeutic & Sports Massage Specialists

Client Health History

HTSMC respects the privacy of our clients. Your personal information will not be collected, used or disclosed without the your prior consent, except where required or permitted by law.

FIRST NAME: **LAST NAME:**

BIRTHDATE:(m) **(d)** **(y)** **MALE ___** **FEMALE___**

ADDRESS: **POSTAL CODE:**

CITY: **PROVINCE:**

PHONE NUMBERS:CELL: **HOME:** **WORK:**

EMERGENCY CONTACT NAME: **PHONE:**

MEDICAL DOCTOR ATTENDING NAME: **PHONE:**

OCCUPATION: **HOW LONG:** **PRIOR OCCUPATION:**

PHYSICAL OCCUPATION DEMANDS (e.g. physical labour, desk, service,)

RECREATION/HOBBIES/ACTIVITIES

PRESENTING COMPLAINTS: **DURATION AND HISTORY OF COMPLAINTS:**

MEDICAL TREATMENT FOR COMPLAINT YES_____ NO_____ TYPE:

AGGRAVATING FACTORS: **ALLEVIATING FACTORS:**

SURGERIES, CAR ACCIDENTS, PHYSICAL INJURIES AND/OR TRAUMAS YOU HAVE EXPERIENCED

TYPE_____ DATE_____TREATMENT_____

CHECK WHAT APPLIES TO DESCRIBE THE PAIN: ____SHARP ____ACHY ____TINGLING
____NUMBNESS ____DULL ____ WORSE AT NIGHT ____WORSE AT NIGHT

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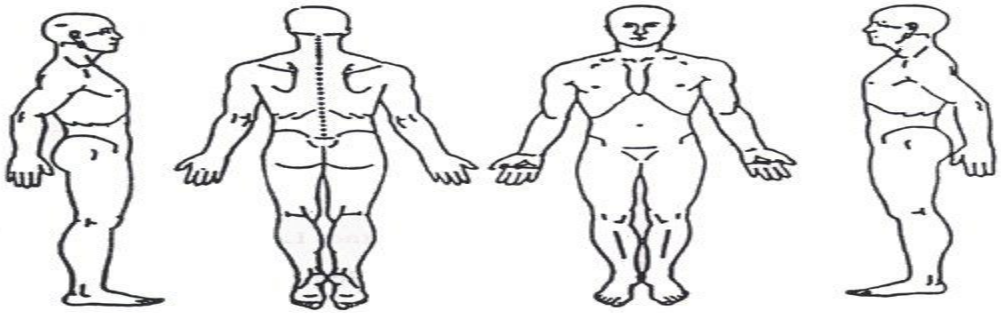
PLEASE CHECK ALL THAT APPLY TO YOU CURRENTLY OR IN THE PAST

__HEADACHES __STROKE __HARSH FALLS __UNEXPLAINED BRUISING
__DIABETES __CRAMPS __WHIPLASH __SWELLING __CANCER
__VARICOSE VEINS __FRACTURES __INFECTIONS __FLU/COLD __JOINT PAIN __DISLOCATIONS __SPRAINS
__HIGH BP __LOW BP __RASHES __ALLERGIES __SEIZURES __ASTHMA

INDICATE SITES OF PAIN ON DIAGRAM



ARE YOU CURRENTLY TAKING ANY MEDICATIONS ___NO ___YES

NAME:_____ HOW LONG_____ REASON_____
_____ _____ _____
_____ _____ _____

STIMULANTS SUCH AS CAFFEINE, SMOKING OR ALCOHOL CAN AFFECT YOUR SYMPTOMS. HOW OFTEN DO YOU INGEST THESE STIMULANTS PER WEEK?

ANY ADDITIONAL INFORMATION YOU WOULD LIKE TO BRING TO THE THERAPIST'S ATTENTION:

AGREEMENT FOR TREATMENT

I (print full name)_____understand that my treatment may include ice/heat application or additional assessment and/or treatment procedures. This treatment is intended for my benefit and to provide me with the best possible treatment. I understand that the actual hands on massage treatment may vary from session to session.

I understand that the massage work received is provided for the basic purpose of either relaxation, stress reduction, and/or relief of muscular tension. I further understand that the massage should not be constructed as a substitute for medical examination, diagnosis or treatment and that I should seek other qualified medical attention for mental or physical ailment that I am aware of.

I understand that massage therapists are not qualified to perform skeletal adjustments, diagnose and/or prescribe and that nothing said in the course of the session should be construed as such.

Because massage is contraindicated under certain conditions, I affirm that I have stated all my known medical conditions and have answered all questions honestly. I agree to keep the therapist updated as to any changes in my medical profile and understand that there shall be no liability on the therapist's part should I fail to do so.

I understand that any illicit or sexually suggestive remarks or advances made by me will result in immediate termination of the session and I will be liable for payment in full of the scheduled appointment.

Signed:_____ Date:_____

Whom should we thank for referring you to our clinic?

__Doctor/Chiropractor_____ Friend_____

__website __Google __Yellow Pages __walk-by saw sign

other:_____

We reserve the right to charge for any appointments missed or any appointment cancellations without 8 business hours prior notice of appointment time