***Kent Massage Therapy & Wellness Centre***

**-- Confidential Health History --**

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Postal Code: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Home Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date of Birth: D \_\_\_\_\_\_ M \_\_\_\_\_\_\_ Y \_\_\_\_\_\_\_\_ Bus/Cell Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Occupation: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ MD Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Referred By: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Email:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Have you received massage therapy before ? **** Yes ****No

Do you have a specific complaint? Please describe: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

How would you describe your general health status? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Are you interested in strategies to help you continue to feel well or even better? ****Yes ****No

Please indicate conditions you are experiencing or have experienced:

***Cardiovascular Head and Neck Infections***

****High blood pressure ****History of headaches ****Hepatitis

****Low blood pressure ****History of migraines ****Herpes

****Chronic congestive heart failure ****Vision problems ****Skin conditions

****Heart attack ****Vision loss ****HIV

****Phlebitis / Varicose veins ****Dizziness ****TB

****Stroke / CVA **** Ear problems

****Pacemaker or similar device ****Hearing loss

****Heart disease

Please list family history of any of the above: ***Other***

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ ****Diabetes (onset ? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_)

****Loss of sensation (where ? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_)

***Respiratory* **Skin irritations

****Chronic cough ****Cancer (where ?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_)

****Shortness of breath ****Arthritis (where ? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_)

**** Bronchitis ****Allergies ( what ? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

****Asthma reaction ?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_)

****Emphysema

Please list family history of any of the above:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ ****Pregnancy (due date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_)

Current medications and conditions they treat: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Surgery and dates: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Injuries and dates: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Other medical conditions: (ie. Digestive, gynecological, hemophilia, etc.) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Of special note: (internal pins, wires, artificial joints, special equipment) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Are you currently involved in other health care? (ie. Physiotherapy, Chiropractic) ****Yes **** No

If yes, please specify and name practitioner: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_



Please indicate on the diagram if you are experiencing any of the following…

PAIN: Yes No (dull, sharp, shooting…?)

Please ***circle*** areas of pain on the diagram

STIFFNESS: Yes No (muscle, skin, joint…?)

Please mark an ‘**X**’ on stiff areas

NUMBNESS: Yes  No (tingling, lack of sensation…?)

Please indicate with ***////*** on the diagram

An accurate health history is important to ensure that it is safe for you to receive massage therapy treatment. If your health status changes in the future,

please let us know.

All information gathered is confidential. You will be asked to provide written authorization for the release of any information.

You always have the right to modify, terminate or refuse treatment at any time, regardless of prior consent given. If you have any questions about massage therapy

or specifics of your treatment, please feel free to ask.

**Massage Therapy Prices**

45 min $80.00

60 min $96.00

90 min $145.00

120 min $180.00

All prices include HST

You will be issued an insurance receipt upon payment

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**Cancellation Policy**

As a courtesy to your therapist and other clients wishing to book appointments,

***24 business hours*** notice is required for cancellation of booked appointments.

***Full fee will be charged for missed appointments without 24 business hours notice.***

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\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Client Signature

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Updated:

Date