Patient History

Name _____
Address _____
Postal Code _____
Email Address _____
Occupation _____

Home Phone _____
Cell Phone _____
Work Phone _____
Birth Date _____
Referred By _____
Last Physical _____

Symmetry
Massage Therapy

Therapist's Use

Ref to:(pls check)
Therapist ☐
Symmetry ☐
No ref ☐

Do you have a history of any of the following in the last 5 years? (Check Box)

- ☐ High/Low Blood Pressure
- ☐ Nervous System Disorders
- ☐ Jaw Pain
- ☐ Disorders of the Digestive System
- ☐ Circulatory Conditions
- ☐ Conditions of the Respiratory System
- ☐ Skin Conditions or Irritations
- ☐ Allergies
- ☐ Diabetes
- ☐ Heart Conditions
- ☐ Headaches
- ☐ Whiplash
- ☐ Fainting or Dizziness
- ☐ Cancer
- ☐ Blood Borne Diseases
- ☐ Current Pregnancy

Does your immediate family have any history of the above conditions?
Which conditions? _____

Current medications or natural remedies

_____
_____

History of surgeries

_____
_____

History of muscle, bone and/or joint injuries

_____
_____
_____

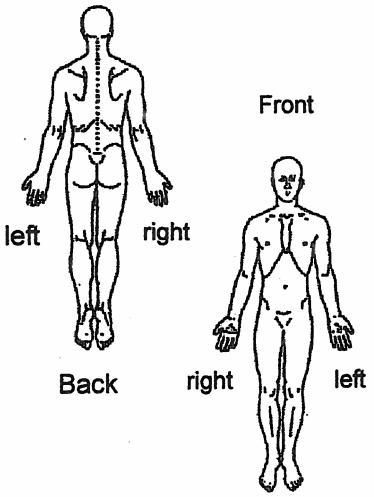
Current Exercise program

_____
_____

What is your specific area of concern?

_____
_____
_____

Please mark the areas that you feel pain with an "x" and circle areas that have other sensations.



Have you had any of the following regarding your present conditions? (Please check)

- ☐ Physician's Examination
- ☐ X-ray
- ☐ Chiropractic Treatment
- ☐ Physiotherapy
- ☐ Massage Therapy
- ☐ Other _____

_____

I affirm that I have stated all my known medical conditions and answered all questions honestly. I agree to keep my Massage Therapist updated as to any changes in my medical profile and understand that there should be no liability on the Massage therapist's part should I fail to do so.

Signature _____ Date _____

Professional Communications

Would you like to receive our sendouts? They include Newsletters, reports on Massage Therapy and other Symmetry Massage Therapy notices (please check). ☐yes ☐no
if yes at ☐home or ☐email

NOTE: We do not share our mailing list with any other companies or organizations.

We do reminder calls the day before your treatment. If we do not connect with you directly, can we leave a message on your answering machine (please check)? ☐yes ☐no

How did you hear about us (please check)?

☐Friend
☐Relative
☐Promotion
☐Our Signage
☐Yellow Pages
☐Newspaper
☐Work Colleague
☐Massage Therapy Assoc. of Manitoba
☐Gift Certificate
☐Other _____

Informed Consent

With a relaxation massage, you may experience sleepiness, reduced pain, nausea, and/or disorientation. With a therapeutic massage, you may experience muscle soreness, bruising, and/or feeling of body imbalance.

The above effects for relaxation and therapeutic massage are not inclusive, but represent the usual effects experienced.

If you have any concerns before, during or after treatment, please speak to your Massage Therapist.

Signature _____ Date _____

Notices

We collect personal health information because there are medical conditions where Massage Therapy may not be indicated.

All personal health information is confidential.

Please inform your Massage Therapist of all new changes in your health information at the start of every treatment.

We require **24** hours notice for cancellation, otherwise full fee will be charged.