



**THERAPEUTIC MASSAGE / SPA THERAPY
HEALTH HISTORY
2007 - 2009**

*** Please thoroughly read and answer all questions on all pages of this form. All information provided will help to ensure that you get the type of treatment that is best suited to you. If you have any questions or need additional space please ask reception.**

PERSONAL INFORMATION

Date: _____

Name: _____ Phone (Day): _____

Address: _____

City/Province/Postal Code: _____ Phone (evening): _____

Occupation: _____

Emergency Contact: _____ Phone: _____

Permission to consult with primary health practitioner - YES _____ NO _____
If yes please provide name and phone number _____

If referred please state by whom: _____

MASSAGE / SPA HISTORY

Reasons for consulting **From Within** : _____

Have you ever received a professional massage? Yes (Date) _____ No _____

Have you ever received a professional spa / hydrotherapy treatment? No _____
Yes (Please describe) _____

What did you like about it? _____

What did you not like about it? _____

What results are you expecting from your massage / hydrotherapy (spa) session(s)? _____

CURRENT CONCERN

What is your current concern? _____

Describe the onset : _____

Describe your primary symptoms : _____

Please rate your symptoms : Mild (0-3) _____ Moderate (4-7) _____ Severe (8-10) _____

Are you currently under care by a medical practitioner? Yes _____ No _____

If yes, please provide the **Doctor's diagnosis** and type of treatment you are receiving: _____

Prioritize the areas of your body that you prefer to have worked on : _____

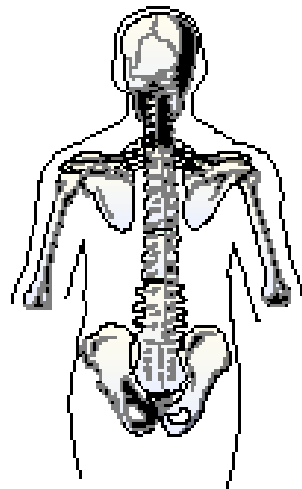
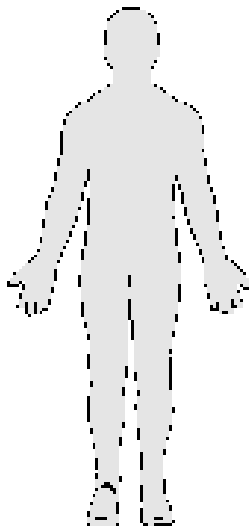
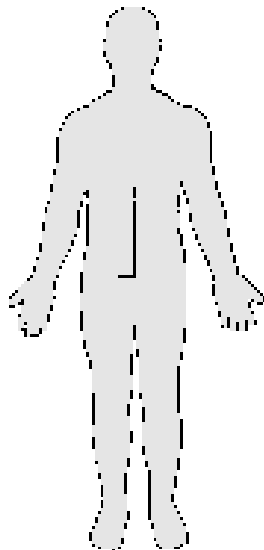
Please list all current medications (including, aspirin/ibuprofen, antihistamines, birth control, Vitamins and herbal / homeopathic remedies) _____

Please describe daily activities / movements that are affected : _____

Discomfort Description:

Key- 'O' Circle over areas of DISCOMFORT AND PAIN **'X'** Over areas of JOINT AND MUSCLE STIFFNESS

'^^' Over areas of NUMBNESS, TINGLING OR ALTERED SENSATION



Additional comments/ concerns: _____

HEALTH HISTORY (include date and description where required. Go back as far as you can)**Surgeries:** _____**Accidents:** _____**Infectious Diseases:** _____

PLEASE INSERT APPROPRIATE DESCRIPTIONS FOR ANY SYMPTOM(S) WHICH YOU MAY NOW OR PREVIOUSLY HAVE HAD. P = past R = reoccurring C = current F = family member affected (relationship)

MUSCULOSKELETAL

Bone / Joint Disease _____
 Broken / Fractured Bones _____
 Lowback/ leg/ hip pain _____
 Neck/ shoulder/ arm pain _____
 Flat feet / high arches _____
 Tendonitis _____
 OsteoArthritis _____
 Rheumatoid Arthritis _____
 Headaches / Injuries _____
 Bursitis _____
 Sprains / Strains _____
 Spasm / Cramp _____
 Jaw / TMJ pain _____
 Other: _____

CIRCULATORY

High Blood Pressure _____
 High BP Medicated _____
 Low Blood Pressure _____
 Varicose Veins _____
 Heart Condition _____
 Lymph edema _____
 Other: _____

RESPIRATORY

Chest pain _____
 Difficulty Breathing _____
 Chronic Cough _____
 Ear Aches _____
 Asthma _____
 Allergies _____
 Other: _____

SKIN

Sensitive _____
 Dryness _____
 Athletes Foot _____
 Psoriasis _____
 Bruise Easily _____
 Rashes _____
 Eczema _____
 Allergies _____
 Warts _____
 Other: _____

GENITO-URINARY

Frequent Urination _____
 Prostate Trouble _____
 Menopause _____
 Kidney Infection _____
 Painful Urination _____
 Pregnant (full term) _____
 Pregnant _____
 PMS _____
 Other: _____

DIGESTIVE

Irritable Bowel Synd _____
 Gas / Bloating _____
 Constipation _____
 Diverticulitis _____
 Nervous Stomach _____
 Diarrhea _____
 Other: _____

NERVOUS SYSTEM

Numbness / Tingling _____
 Chronic Pain _____
 Herpes/ Shingles _____
 Sleep Disorder _____
 Fatigue _____
 Other: _____

OTHERS

Mental Health Condition _____
 Nicotine _____
 Drug Consumption _____
 Alcohol Consumption _____
 Cancers/ Tumors _____
 Poor Nutrition _____
 Diabetes _____
 Caffeine _____
 Food Allergies _____
 Claustrophobic _____
 Fibromyalgia _____
 Multiple Sclerosis _____
 Lupus _____

INSURANCE INFORMATION

It is the policy of **FROM WITHIN** that regardless of the patient's individual health insurance coverage for massage / hydrotherapy, payment is to be made at time of service. (MVA protocols non withstanding.) Receipts are provided for the patient to arrange reimbursement. Receipts will only be issued for the patient in his / her name **ONLY**, for date that service is provided. Our massage therapists are registered with the Association of Massage Therapy and Wholistic Practitioners (AMTWP) .

WAIVER

I have stated **all medical conditions** that I am aware of. I **agree to update** my massage therapist **of any change in my health status. I agree to inform** the therapist **immediately** if **I experience any pain or discomfort during my massage / spa treatment**, so that the temperature, time, pressure and / or strokes may be adjusted to my level of comfort. I assume all risks and responsibilities from any injury or liability that may occur as a result of this session.

DATE: _____

SIGNATURE: _____

INITIAL FINDINGS / TREATMENT