New Massage Patient Form

Lendrum Health Centre. 5846-111 Street. Edmonton, AB. T6H 3G1

			Date: / /	
First Name:	Last Name:	Date of Birth: / /	Age:	Sex:
Address:	City/Province:	Postal Code:	Ph(H):	
Occupation:	Marital Status: S M D W	E-Mail:	Ph(W):	
AHC:	How did you hear about us?		Ph(C):	

Have you received a professonal massage before? ☐ Yes ☐ No If yes, when was your last one? _____

What results would you like to achieve through massage therapy? _____

Are you currently under the care of a medical practitioner? ☐ Yes ☐ No For what? _____

_____

Please list all medications/supplements you are currently on: _____

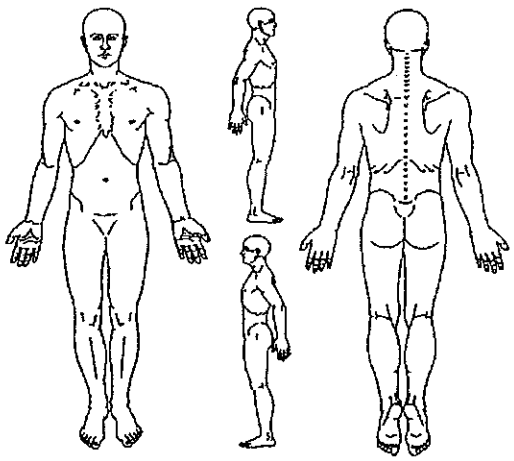
_____

Please list any allergies you may have: _____

Please list all stress reduction and exercise activities (Include frequency): _____

_____

Please use these diagrams to indicate the main area of concern as well as any other areas of pain, stiffness, discomfort or injury in your body:



Physical Stress

Have you had any surgeries? ☐ Yes ☐ No When and for what? _____

Have you had any Trauma/injury/fractures? ☐ Yes ☐ No Explain? _____

Please list any prolonged postures or positions you hold your body in for extended periods, past or present. _____

_____

Please check any of the following symptoms or conditions that apply to you:

- ☐ Arthritis
- ☐ Osteoporosis
- ☐ Any Numbness or Tingling
- ☐ Changes in hand/feet temperature
- ☐ Changes in normal muscle strength
- ☐ Changes in balance or co-ordination
- ☐ Asthma or other Respiratory problems
- ☐ Nausea
- ☐ Migraines
- ☐ Fatigue
- ☐ Anxiety/Depression
- ☐ Ringing in ears
- ☐ Blurred Vision
- ☐ Bleeding Nose
- ☐ Heart Condition
- ☐ Poor Circulation
- ☐ High or Low Blood Pressure
- ☐ Skin problems
- ☐ Poor digestion
- ☐ Acid Reflux
- ☐ Bloating

Is there anything else about your health or life circumstances which you think may be relevant?

INFORMED CONSENT

I hereby request and consent to receive Massage Therapy from a Registered Massage Therapist in this office. I agree to Communicate with my Massage Therapist in order to build a treatment plan that will suit me.

I understand that Massage Therapy is intended to enhance relaxation, reduce pain caused by muscle tension, increase range of motion, improve circulation, improve body awareness, increase sense of well-being, and offer a positive experience of touch.

The general benefits of massage, possible massage contraindications and the treatment procedure have been explained to me. I understand that massage therapy is not a substitute for medical treatment or medications, and that it is recommended that I concurrently work with my Primary Health Care Provider for any condition I may have. I am aware that the massage therapist does not diagnose illness or disease, does not prescribe medications, and that spinal manipulations are not part of massage therapy.

I have informed the massage therapist of all my known physical conditions, medical conditions and medications, and I will keep the massage therapist updated on any changes.

PATIENT NAME _____ PATIENT SIGNATURE _____ DATE _____

I understand that there is a cancellation fee for missed appointments with less than 24 hours notice _____

please initial