swmassage
South West Massage + Wellness Centre

Confidential Patient Health History Form

Name:_____ Birthdate:_____

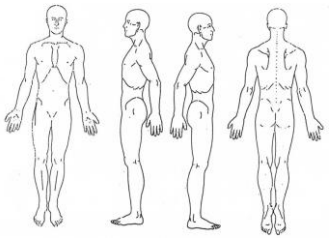
Address:_____City:_____PostalCode:_____

Email:_____Occupation: _____

Cell Phone Number: _____ Work Phone Number: _____

Referred by:_____ Emergency Contact Name and Phone Number:_____

Please indicate conditions you are experiencing or have experienced:

Cardiovascular ○ High blood pressure ○ Low blood pressure ○ Chronic congestive heart failure ○ Heart attack ○ Phlebitis/ varicose veins ○ Stroke / CVA ○ Pacemaker or similar device ○ Heart disease / condition ○ Dizziness / Vertigo ○ Seizures Any family history to the above? _____	Respiratory ○ Asthma ○ Bronchitis ○ Emphysema ○ Chronic cough ○ Shortness of Breath ○ COPD Any family history to the above? _____	Digestive ○ Constipation ○ Crohn's disease ○ Colitis ○ Irritable Bowel Syndrome ○ Ulcers ○ Other _____
Head and Neck ○ History of headaches ○ History of migraines ○ Vision problems ○ Vision loss ○ Ear problems ○ Hearing loss ○ Other _____	Muscle / Joint ○ Circle areas of complaint  ○ Previous MVC or trauma ○ Disc problems ○ List previous injuries and surgeries _____	Other ○ Reaction to applied heat? Cold? _____ ○ Loss of sensation Where?_____ ○ Diabetes Onset_____ Type_____ ○ Allergies / sensitivities What?_____ ○ Epilepsy ○ Cancer Type_____ Location_____ ○ Arthritis ○ Hemophilia ○ Chronic Fatigue ○ Fibromyalgia ○ Scolosis ○ Polio / Post Polio ○ Osteoporosis
Women ○ Pregnancy Due Date:_____ ○ Previous pregnancy complications ○ Menstrual problems ○ Gynecological conditions	Infections Conditions ○ Skin conditions_____ ○ HIV ○ Respiratory conditions ○ Hepatitis Skin Conditions ○ Eczema ○ Psoriasis ○ Rash ○ Warts ○ Herpes	Do you have any artificial joints, pacemakers, internal wires or special equipment that we should be aware of? _____ For what condition or reason are you seeking treatment today?_____ What are you expecting to achieve with Massage Therapy?_____ Please list medication, vitamins, herbs _____

Accurate health information is important to ensure that it is safe for you to receive Massage Therapy. If there are any changes to your health, please inform your Therapist. All information gathered is confidential and is only shared among Therapists to facilitate your treatment and care. Any sharing of your information with third parties requires your written authorization.

☐ I understand that Massage Therapy may include several modalities in addition to manual therapy.

Massage Therapy at South West Massage may include: Cupping Therapy Hot/Cold Stones GuaSha Energy work Lymphatic Drainage Reflexology

By signing below, I consent to receiving these additional modalities and understand that I may discuss, change/modify/withdraw my consent, at any time by informing my therapist.

☐ I understand and will adhere to the 24hour cancellation policy to avoid charges being applied to my account.

Signature:_____ Date:_____