Tree Frog Massage Therapy

Deborah Van Leer RMT, DipCOT

www.treefrogmassage.com

Client Intake & Health History Form

An accurate health history ensures that it is safe for you to receive a massage treatment, helping your therapist determine a proper treatment plan. If and when your health status changes in the future, please let us know. All information gathered on this form is confidential. Your written authorization is legally required before any of this information can be released.

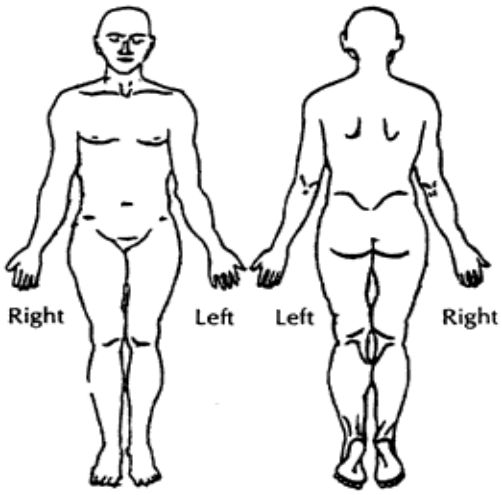
Personal Information

Name: _____
Address: _____ _____Post Code: _____
Home Phone: _____Cell: _____ Occupation: _____
Date of Birth: _____Email: _____
Doctor: _____Phone: _____ May I contact? Yes No
Emergency Contact Name: _____Phone: _____

Have you had a massage before? Yes No
For relaxation or other reason? _____
Are you currently taking any medications? Yes No
If yes, please list name and reason for
medications_____
Are you currently seeing a healthcare professional? Yes No
If yes, please list names and reason/treatment :
_____
Have you been referred to me by another healthcare professional? Yes No
If yes, please list names and reason for referral
_____
May I contact them? Yes No
Have you taken any anti inflammatory medication, pain killers, muscle relaxants or mood altering medication within the past 24 hours? Yes No
If Yes, what and how much?_____
Have you had any allergic reactions to any medications? Yes No
If Yes, to what? _____

Do you have any of the following? (Please circle)
Internal pins Wires Artificial Joints Special Equipment

Indicate with an (X), if any, the areas in which you are feeling discomfort:



Please indicate any areas you would prefer not to be included in your Treatments. (This can be discussed further with your therapist).

Primary Complaint:

When, how did it begin?

What aggravates the condition?

What relieves the condition?

Do you do regular exercise? Yes No Type: _____Frequency: _____

Leisure Activities:_____

Do you eat a balanced diet? Do you take any dietary supplements?

Is your energy level: High Average Low
Do you suffer from stress? Yes No

Please indicate all conditions you have experienced. Mark with an * if there is a family history.

Joint/Soft Tissue Discomfort:
__ Arms
__ Upper Back
__ Mid Back
__ Lower Back
__ Degenerative Discs
__ Feet
__ Hands
__ Hips
__ Jaw
__ Knees
__ Legs
__ Neck
__ Osteo Arthritis
__ Rheumatoid Arthritis
__ Sciatica

Skin:
__Rashes
__Itching
__Bruise Easily
__Dryness
__Boils

Other _____

Headaches:
__ Tension
Frequency?
__ Migraines
Frequency?

Infectious:
__ Hepatitis
__ Tuberculosis
__ Human Immunodeficiency Virus(HIV)
__ Herpes
__ Cold
__ Flu
__ Athlete's Foot
__ Warts

Limitation of Movement:
__ Neck
__ Shoulders
__ Elbows
__ Wrists
__ Hands
__ Low back
__ Hips
__ Knees
__ Ankles
__ Feet

Digestive:
__ Poor Appetite
__ Belching/Gas
__ Constipation
__ Diarrhoea
__ Nausea
__ Ulcer
__ Vomiting

Eye, Ear, Nose, Throat:
__ Allergies
__ Frequent Colds
__ Glasses or Contacts
__ Hearing Aid
__ Hearing Loss
__ Sinus Infection
__ Swollen Glands

Reproductive:
__ Pregnant
due date:
__ Painful Menstruation
__ Heavy Flow
__ Irregular Cycle
__ Swollen Breasts
__ Menopausal
__ Pre-menopausal

Respiratory:
__ Chronic Cough
__ Bronchitis
__ Asthma
__ Hay Fever
__ Difficulty Breathing
__ Smoking
__ Emphysema
__ Pneumonia

General Symptoms:
__ Fainting
__ Dizziness
__ Loss of Sleep
__ Nervousness
__ Fatigue
__ Sudden Weight Loss/Gain
__ Numbness
__ Tingling
__ Paralysis

Cardiovascular:
__ High Blood Pressure
__ Low Blood Pressure
__ Coronary Heart Disease
__ Heart Attack
__ Phlebitis
__ Stroke / CVA
__ Pacemaker
__ Heart Murmur
__ Palpitations
__ Varicose Veins
__ Swelling of the Ankles
__ Poor Circulation

__ **Motor Vehicle Accidents?**
Please indicate when, what injuries?

Previous accidents, injuries, surgeries:

Please read carefully, and sign.

- I attest that the information I have provided is true and complete to the best of my knowledge.
- I am responsible for notifying my massage therapist if I am currently experiencing a cold/flu, fever, infection or any contagious disease
- I understand the information I have provided on this form is confidential and will not be released without my written consent.
- I also understand that I am responsible for any charges incurred in the course of my treatment and that 24 hours notice is required to cancel an appointment, or full charges will apply.
- Payment, in full, will be due at the time of treatment.
- I understand that although massage or other integrative therapy can be very therapeutic, relaxing and reduce muscular tension, it is not a substitute for medical examination, diagnosis and treatment.
- This is a therapeutic or relaxation massage (or other integrative therapy) and any sexual remarks or advances will terminate the session and I will be liable for payment of the scheduled treatment.
- Being that massage (or other integrative therapy) should not be done under certain medical conditions, I affirm that I have answered all questions pertaining to medical conditions truthfully.

Signature_____ Date_____

I became aware of *Tree Frog Massage Therapy* through ————————————————————————-

I would like to receive occasional information regarding Massage Therapy and wellness Yes No

(Information will also be available on the Tree Frog Massage Therapy Facebook page.)

I would like to receive reminders of upcoming appointments Yes No

You are able to change your e-mail preferences at any time.