WELCOME TO ELEVATE LIFE MASSAGE THERAPY
PATIENT HISTORY

Name: _____ Date: _____
Home #: _____ Work #: _____ Cell #: _____
Address: _____
City: _____ Province: _____ Postal Code: _____
Occupation: _____ Employer: _____
Birth Date: _____
Email *: _____
***If you would like to subscribe to our appointment reminders, newsletters, educational and lifestyle information**

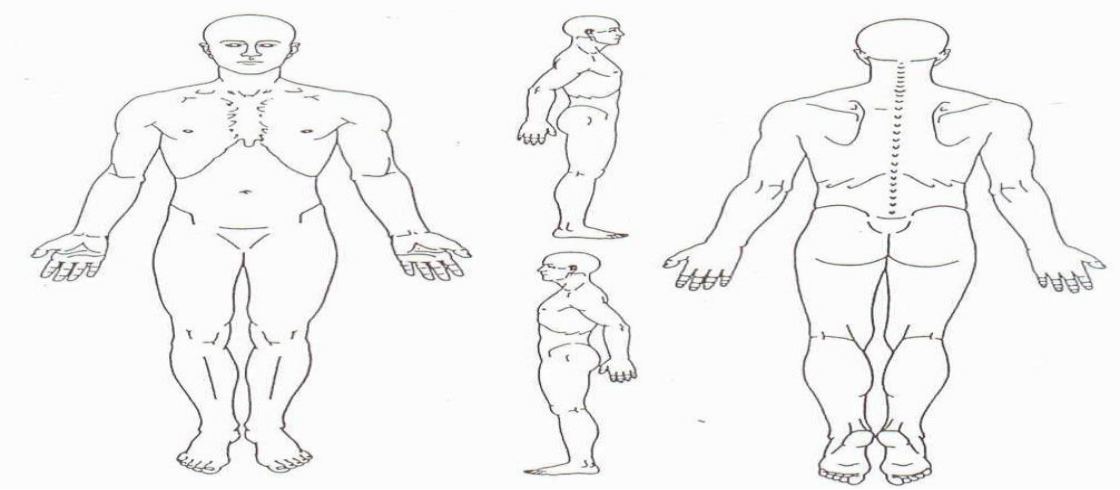
Doctor's name & location: _____
Phone#: _____ Last physical examination: _____
Emergency contact name and #: _____

Who referred you? _____

Reason you need Massage Therapy?
_____MVA _____Injury _____Pain _____Stress _____Relaxation
What have you tried for relief?
_____Heat _____Cold _____Exercise _____Other

List any allergies (esp. oils, nuts, etc.): _____
_____

Please indicate where you are experiencing pain:



FOR THERAPIST ONLY: _____
_____
_____
_____

ELEVATE LIFE MASSAGE THERAPY
CLIENT CASE HISTORY OUTLINE

Any surgery/injury type and date: _____

_____

_____

Current medications & conditions treated: _____

_____

_____

Recent steroid or cortisone injection: _____Yes _____No

Previous Motor Vehicle Accidents:

Date: _____ Date: _____

Date: _____ Date: _____

Other injuries: _____

Please check off any of the following conditions you experience frequently

HEAD/NECK
____ Headaches
Type: _____
Location: _____
Frequency: _____
____Vision problems
____Nausea
____Dizziness
____ Jaw pain
____ Neck pain
____ Contact lenses
____ Ear aches
____ Whiplash
Other: _____

MUSCLES/JOINTS
____ Back pain
____ Shoulder pain
____ Arm pain
____ Leg pain
____ Foot pain
____ Hip pain
____ Joint pain
____ Limited movement
____ Rheumatoid Arthritis
____ Osteoarthritis
____ Bursitis
____ Fracture
____ Cramping

SKIN
____ Sensitive Skin
____ Skin diseases
____ Cold sores
____ Rashes/Eruptions
____ Bruise easily
____ Contagious condition

RESPIRATORY
____ Chronic cough
____ Short of breath
____ Light smoking
____ Heavy smoking
____ Pain coughing
____ Frequent colds
Other: _____

CARDIOVASCULAR
____ High blood pressure
____ Low blood pressure
____ Poor circulation
____ Swelling
____ Heart disease
____ Heart condition
____ Varicose Veins
____ Short of breath
Other: _____

DIGESTIVE/UROGENITAL
____ Poor Appetite
____ Constipation
____ Irritable bowel
____ Diarrhea
____ Hypoglycemia
____ Kidney/Bladder
Other: _____

IMMUNE SYSTEM
____ Asthma
____ HIV positive
____ AIDS

OTHER HEALTH CARE
____ Chiropractic
____ Physiotherapy
____ Previous massage

NERVOUS SYSTEM
____ Nervous/Depressed
____ Tingling
Where? _____
____ Numbness
Where? _____
____ Weakness
Where? _____
____ Fatigue
____ Insomnia
____ Sciatica
____ Epilepsy

GENERAL
____ Left handed
____ Right handed
____ Good sleeping habits
____ Regular exercise
____ Eat healthy
____ Positive Mental attitude
____ Weather affects you

FOR WOMEN ONLY
____ Pre-menstrual syndrome
____ Pregnant
Due date: _____
____ Menopausal symptoms

ELEVATE LIFE MASSAGE THERAPY
CONSENT FORM

If you have any questions with regards to this consent form, or regarding treatment, your therapist will discuss this with you.

All information provided will be held in STRICTEST CONFIDENCE unless receiving a WRITTEN request, along with a signed release from the client. ALL or PART of the client's records can be released to the client, the client's personal representatives: (a) lawyer (b) insurance company (c) other health care professionals (d) others.

Draping defines the physical boundary between the client and the therapist. Client privacy and respect will be assured at all times. The client may choose to be fully draped or clothed throughout the treatment. Genitals, perineum and / or anus are NEVER undraped.

- **A client has the right to refuse, modify or terminate treatment at any time.**
- **A therapist has the right to refuse, modify or terminate treatment at any time if there is reasonable cause.**
- **Needs assessments, treatment, procedures, benefits and risks of treatment will be discussed with the client.**

FULL FEES WILL BE CHARGED FOR MISSED OR LATE APPOINTMENTS.

ANY CANCELLATIONS MADE MUST BE 48 HOURS PRIOR TO APPOINTMENT TIME TO AVOID THE ABOVE CHARGES.

PLEASE NOTE WHERE INSURANCE IS CONCERNED, THE CLIENT IS RESPONSIBLE TO PAY FOR MISSED APPOINTMENTS.

Client signature: _____

Name (Please print): _____

Massage Therapist Signature: _____

Date: _____