Massage Therapy

APPOINTMENT POLICY:

Thank you for choosing Lifepath Massage Therapy. We look forward to a long relationship in the care of your overall well being. Please be aware that 24 hours notice is required for any changes to appointments. ***Should sufficient notice not be provided the full fee of the appointment will be charged to your account.***

YOUR PERSONAL INFORMATION

Name: _____
LAST *FIRST* *MIDDLE INITIAL*

Address: _____

City: _____ Prov: _____ Postal Code: _____

Home Phone: _____ Work Phone: _____ Cell Phone: _____

Email address: _____ Birthdate: _____ / _____ / _____ GENDER: M / F
DAY MTH YR

Occupation: _____ Employer: _____

How did you hear about our office? _____

MEDICAL HISTORY **Please check all that apply to you:**

__HIV OR AIDS
__ALCOHOL OR DRUG ABUSE
__ANEMIA
__ARTHRITIS
__ARTIFICIAL VALVES/JOINTS/PINS
__ASTHMA (INHALER: Y / N)
__BLOOD DISORDER
__BREASTFEEDING CURRENTLY
__CANCER
__CONGESTIVE HEART FAILURE
__DIABETES (INSULIN: Y / N)
__DIZZINESS/FAINTING
__EPILEPSY
__EXCESSIVE BLEEDING
__GLAUCOMA
__GROWTHS OR TUMORS
__HAY FEVER
__HEAD INJURIES
__HEART DISEASE
__HEART MURMER
__HEPATITIS (TYPE _____)
__HIGH BLOOD PRESSURE
__JAUNDICE
__KIDNEY DISEASE
__ LIVER DISEASE
__LOW BLOOD PRESSURE
__MENTAL OR NERVOUS DISORDERS
__PACEMAKER
__RADIATION TREATMENT
__RESPIRATORY PROBLEMS
__RHEUMATIC FEVER
__SINUS PROBLEMS
__SMOKER
__STD/VENEREAL DISEASE
__STOMACH PROBLEMS
__STROKE (WHEN _____)
__TMJ PROBLEMS
__TUBERCULOSIS
__ULCERS

Women: Are you pregnant or planning a pregnancy? _____ Expected date of delivery: _____

What is the specific reason for your visit? (i.e.: injury, MVA, sports, relaxation, etc.)
_____

Name of Family Doctor: _____ Phone: _____

Have you been under the care of a physician recently? _____

Are you currently seeing a Chiropractor? _____Chiropractor's Name:_____

List all medications, pills or vitamins and herbs you are presently taking: (Prescription and over the counter please)
_____

***Consent to treatment**: **To the best of my knowledge all of the preceding answers and information provided are true, complete and accurate. If I ever have changes to my health, or medications I will inform the massage therapist at my next appointment. I grant permission to you and your assignees to telephone me to discuss matters related to this form. I assume responsibility for all fees associated to my massage treatment.**

Today's Date: _____ Signature of Patient, Parent or Guardian: _____