MEDICAL HISTORY

Last Name _____ First Name _____

Address _____ Birthday _____
Street City D/ M/Y

_____ Home Phone _____
Province Postal Code

Email Address _____

Occupation _____ Business Phone _____

Emergency Contact _____ Phone _____

Doctor's Name _____ Phone _____

GENERAL & MEDICAL INFORMATION

Is this your first massage? YES NO
How did you hear about the clinic? _____
What brings you in for a massage? Stress / Pain Relief / Tension / Other _____
Is your condition related to work? YES NO
Are you currently having discomfort or pain? YES NO

Do you know the cause of pain? _____

When do you experience the pain? _____

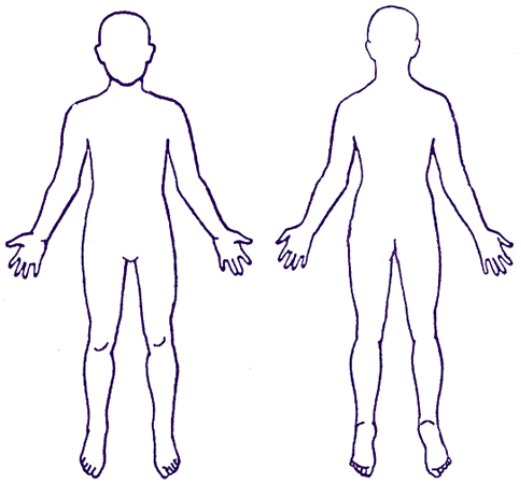
How long have you had the pain? _____

How would you describe the pain? (sharp, dull, burning, numbness, tingling)
Please describe _____

Is there something that relieves the pain? _____

Is there something that aggravates it? _____

Have you seen your family Doctor lately for this particular problem?
And has he/she recommended any treatment? _____



Please mark areas of pain on the diagram

Have you had any surgery? If YES, when? _____
Please describe _____

If this is a result of a Motor Vehicle Accident, Please provide the following information:

Date of the Accident _____

Previous Motor Vehicle Accidents _____

PLEASE TURN OVER……

Do you **PRESENTLY** suffer from any of the following? (Please circle)

Infectious Disease Headaches Joint Pain (Arthritis) AIDS HIV Positive

Cancer High Blood Pressure Low Blood Pressure Tingling/Numbness

Muscle Cramps Jaw Pain Skin Conditions Varicose Veins Allergies

Do you suffer from any other condition **NOT** mentioned above? YES NO
If YES, Please describe _____

Are you currently taking any medication? YES NO
If YES, Please describe _____

Please read carefully:

I understand that my massage treatment may include an ice/heat application or an assessment. These treatments are used for my benefit and to provide me with the best treatment possible although the actual hands on massage therapy that I receive may vary.

I understand that the massage I receive is provided for the basic purpose of relaxation, stress reduction, and relief of muscular tension. I further understand that massage should not be construed as a substitute for medical examination, diagnosis, or treatment and that I should see a physician or other qualified medical specialist for mental or physical ailments that I am aware of.

I understand that massage therapists are not qualified to perform skeletal adjustments, diagnose and/or prescribe, and that nothing said in the course of the session should be construed as such.

Because massage is contraindicated under certain conditions, I affirm that I have stated all my known medical conditions and answered all questions honestly. I agree to keep the therapist updated as to any changes in my medical profile and understand that there shall be no liability on the therapist's part should I forget to do so.

All information in my file is confidential. Country Hills Massage Therapy will not release any information from my file unless I have signed a release form authorizing them to do so.

CANCELLATION POLICY:
If you are unable to make an appointment, please give Country Hills Massage Therapy 2 hours cancellation notice. You will be responsible for the full amount of your treatment for failure to do so. We thank you in advance for your cooperation.

Signed _____ ***Date*** _____

Therapist _____ ***Date*** _____

THIS SECTION IS FOR THE THERAPIST ONLY

Progress Notes Of First Treatment: