Chiani Wellness Centre

Unit 3 – 2990 Horton Road, Mill Bay, BC V0R 2P3
Tel 250-743-6616 www.yourfullpotential.ca

Massage Therapy Health History

First Name _____ **Initial** ____ **Last Name** _____

Care Card # _____ **Date of Birth (M/D/Y)** _____

Address _____

City _____ Postal Code _____

Mailing address (if different from above) _____

Home Phone _____ Work Phone _____ Cell Phone _____

Email _____

Occupation _____ Employer _____

Spouse _____ Children (names/ages) _____

Activities _____ Medical Doctor _____

Medications _____ Allergies _____

History of Cancer _____ **HIV** ☐ Yes ☐ No **Hepatitis** ☐ Yes ☐ No

Are you pregnant? ☐ Yes ☐ No Due Date _____

Who referred you to us? _____ **or How Did You Choose Us?** _____

Do you have insurance coverage? Company? _____ **Policy #** _____ **Group #** _____

Policy Holders Name: _____ **Policy Holders DOB:** _____

Current Health Condition

What is your present complaint? _____

_____

Do you know the cause? _____

When do you experience this? *(morning, evening, sleeping, during / after activity)* _____

_____

Describe symptoms *(throbbing, burning, dull, cramping, numbness, tingling, sharp, shooting)* _____

_____

Duration of symptoms *(constant, intermittent, brief)* _____

_____

What relieves? _____

What aggravates? _____

OVER →

Please check any that apply:

- ☐ Morning Stiffness
- ☐ Painful / Swollen Joints
- ☐ Crunching / Grinding Joints
- ☐ Pins / Plates / Prosthesis
- ☐ Bone Pain
- ☐ Weakness
- ☐ Rheumatoid Arthritis
- ☐ Osteoarthritis
- ☐ Osteoporosis
- ☐ Diabetes Type I / Type II
- ☐ Headaches: Tension / Migraine
- ☐ Dizziness / Fainting
- ☐ Ringing in Ears
- ☐ Jaw (TMJ) Pain
- ☐ Fatigue
- ☐ Fibromyalgia
- ☐ Eczema, Psoriasis
- ☐ Abdominal Pain
- ☐ Constipation / Diarrhea
- ☐ Urinary Infection
- ☐ Respiratory Infection
- ☐ Asthma
- ☐ Chest Pain
- ☐ High / Low Blood Pressure
- ☐ Heart Attack
- ☐ Stroke
- ☐ Varicose Veins
- ☐ Deep Vein Thrombosis
- ☐ Cold Hands / Feet
- ☐ Color Changes in Fingers / Toes

Previous Injuries / Surgeries _____

Additional condition(s) not listed above _____

_____

_____

_____

I declare the information on this form to be true and correct in all respects. I understand that the Massage Therapist will rely on the information given by me to provide safe treatment. If any information is not correct, I release the Massage Therapist from any and all claims arising out of any treatment provided.

We accept payment by Cash, Debit, Visa, or MasterCard

I understand that all services are to be paid in full at the time of service, unless other arrangements have been made and agreed upon in writing.

Signature _____ **Date** _____

Cancellation Policy

Twenty-four (24) hours notice is required for cancellation or rescheduling of appointments.

Full price will be charged for all missed or late cancel appointments.

As well, please be aware that in order to provide timely service to all of our clients, late arrival to an appointment will result in shorter treatment duration.