MACSKI MASSAGE THERAPY

CLIENT HISTORY FORM

Date:_____ Hm Phone:_____
Name:_____ Wk. Phone:_____
Address:_____ Cell Phone:_____
Postal Code:_____ Birth Date:_____
Email : _____

Occupation: _____
Work Hrs:_____

Primary reason for appointment: _____
_____

Recreational Activities/Hobbies: _____

Have you ever had a Massage or Energy work before? Therapeutic Relaxation None
If yes, why?_____
_____

Are you under a Doctor, Chiropractor or Health Practitioners care? _____
If so for what condition? _____

Have you had any operations,illnesses, accidents, &/or muscle / bone / joint injuries?
_____
_____

Please list any prescribed medications, TX of, and for how long. _____
_____

Are you taking any Herbal remedies? _____

Allergies: _____ Daily water intake: _____
Sleep patterns: _____ Stress Levels: _____
Do you Have an Exercise routine: _____
Energy Level: Poor_____ Fair_____ Good _____ Excellent _____
Nutritional habits: Poor____ Fair_____ Good_____ Excellent_____

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Please check and conditions you are presently experiencing and and X beside and you have experienced in the past:

___Heart Conditions
___Circulatory conditions
___Respiratory conditions
___Headaches/migraines
___Fractures
___Osteoporosis
___Arthritis OA/RA
___Fibromyalgia
___Whiplash
___Nervous system disorders
___Seizures
___Fainting /dizziness
___High/low blood pressure
___Diabetes
___Strains/Sprains
___TMJ Problems
___Skin conditions/irritations
___Athletes foot
___Infectious disease
___ Stomach / digestive tract disorders
___ Other: _____

Females only: Are you Pregnant? ____ Nursing?_____ Have you been pregnant before?_____ Any Menstrual / Menopausal problems?_____

_____

How did you Hear about MacSki Massage Therapy? _____

In case of emergency, notify: _____ Phone # _____

I have completed this form to the best of my knowledge. I understand that the services are designed to be a heath aid and in no way take the place of a Doctors care. Information exchanged during the treatment session is educational in nature and is intended to help me become fore familiar and conscious of you own health status and is to be used at my own discretion. Patient confidentiality shall be upheld accordance with the Personal Heath Information Act (PHIA)

Our time together is precious and **I agree to cancel 24 hours in advance,** unless there is an emergency. **If I miss an appointment there is a $35.00 charge.**

Insurance Claims: **I am responsible to pay the full amount if my insurance plan does not cover the balance.**

Date:_____ **PRINT NAME:** _____ **SIGNATURE:**_____