Best of Health Massage Therapy

Client Information & Massage Therapy Waiver

Client Name: _____ Birthdate: _____

Center/Residence: _____ Room #: _____

Address: _____

City: _____ Province: _____ Postal Code: _____

Phone Number: _____

Family Contact: _____ Relationship: _____

Phone Number: _____

Email: _____

Billing Information: ☐ *Check if billing address is same as above*

Attention: _____

Address: _____

City: _____ Province: _____ Postal Code: _____

Invoice delivery preference: ☐ Canada Post ☐ Email

Treatment Time:

- ☐ 15 min
- ☐ 30 min
- ☐ 45 min
- ☐ 60 min

Treatment Frequency:

- ☐ Weekly
- ☐ Bi-Weekly
- ☐ Monthly
- ☐ Other _____

Massage Therapy Waiver:

I understand that massage therapy is for the purpose of stress reduction, relief from muscular tension and spasm, general relaxation and improvement of circulation. I have stated all known medical conditions on the Client Medical History Form. I understand that massage therapy is not a substitute for medical care and it is my obligation to consult with a medical doctor regarding any described conditions. I hereby release and waive Best of Health Massage Therapy and its staff and/or massage therapists from any and all liability, past, present, and future relating to massage therapy.

Client Name: _____

Client/P.O.A. Signature: _____

Date: _____

Best of Health Massage Therapy

Confidential Client Medical History

This history is strictly confidential and will not be released to anyone without your prior written consent. The information gathered will help determine the appropriate type of massage and procedures to be included in your treatment plan.

NAME: _____ DATE: _____

CURRENT CONDITIONS *(As diagnosed by a medical doctor):*

Please check all that apply

- ☐ **Rheumatoid/Osteo Arthritis**
  Please circle and list location(s):
  _____
- ☐ **Heart Disease** *list type:*
  _____
- ☐ **Sprains/Dislocations** *please circle and list location(s):*
  _____
- ☐ **Broken Bones** *list location(s):*
  _____
- ☐ **Contagious Condition** *list:*
  _____
- ☐ **Bursitis/Tendinitis** *list location:*
  _____
- ☐ **Blood Clots** *list location(s):*
  _____
- ☐ **Tumors/Cancer** *please circle and list location(s):*
  _____
- ☐ **Surgeries** *please list:*
  _____
  _____
- ☐ **Chronic Fatigue Syndrome/Fibromyalgia** *please circle*
- ☐ **Ulcers/Colitis/Diverticulitis** *please circle*
- ☐ **Disc Problems – Slipped/Herniated/Bulging/Degenerative Disk Disease** *please circle*
- ☐ **Migraine/Tension Headaches** *please circle*
- ☐ **Dementia/Alzheimers/Confusion/Psychosis** *please circle*
- ☐ **Stroke/Heart Attack** *please circle*
- ☐ **Implants** *plastic or other devices, list location(s):*
  _____
- ☐ **Fusions** *list location(s):*
  _____

- ☐ Multiple Sclerosis
- ☐ Edema
- ☐ Epilepsy
- ☐ Varicose Veins
- ☐ Osteoporosis
- ☐ Tuberculosis
- ☐ Muscular Dystrophy
- ☐ Parkinson's Disease
- ☐ High Blood Pressure
- ☐ Low Blood Pressure
- ☐ Sciatica
- ☐ Asthma
- ☐ Hypertension
- ☐ Carpal Tunnel
- ☐ Skin Allergies
- ☐ Lupus
- ☐ Diabetes
- ☐ Depression
- ☐ Emphysema

Please list any other relevant conditions or concerns:

_____

_____

_____

_____

_____

_____

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