

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

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

_____ | <input type="checkbox"/> Multiple Sclerosis |
| | <input type="checkbox"/> Edema |
| | <input type="checkbox"/> Epilepsy |
| | <input type="checkbox"/> Varicose Veins |
| | <input type="checkbox"/> Osteoporosis |
| | <input type="checkbox"/> Tuberculosis |
| | <input type="checkbox"/> Muscular Dystrophy |
| | <input type="checkbox"/> Parkinson's Disease |
| | <input type="checkbox"/> High Blood Pressure |
| | <input type="checkbox"/> Low Blood Pressure |
| | <input type="checkbox"/> Sciatica |
| | <input type="checkbox"/> Asthma |
| | <input type="checkbox"/> Hypertension |
| | <input type="checkbox"/> Carpal Tunnel |
| | <input type="checkbox"/> Skin Allergies |
| | <input type="checkbox"/> Lupus |
| | <input type="checkbox"/> Diabetes |
| | <input type="checkbox"/> Depression |
| | <input type="checkbox"/> Emphysema |

Please list any other relevant conditions or concerns:
