CONFIDENTIAL HEALTH HISTORY

The information requested below will help assist us in treating you safely.
Note that all information provided below will be kept confidential unless allowed or required by law. Your written permission will be required to release any information.

Name: _____
Address: _____
City: _____Postal Code: _____
Date of Birth: (D)_____(M)_____(Y)_____
Occupation:_____

Family Physician:_____
Physician Address:_____
Phone:_____

What brings you in for massage?
□ Relaxation □ Stress □ Injury □ Pain

Date: _____
Phone (h): _____
Phone (c): _____
Phone (w):_____
Cell Phone Provider: _____
E-Mail:_____

Would you like to receive an SMS or email appointment reminder? □ YES □ NO

Date of Last Massage: _____

Please check any conditions you are experiencing or have experienced:

CIRCULATION
□ HIGH BLOOD PRESSURE
□ LOW BLOOD PRESSURE
□ HEART CONDITION
□ HEART ATTACK □STROKE
□ VARICOSE VEINS / PHLEBITIS
□ PACEMAKER
□ POOR CIRCULATION
□ DIZZINESS

RESPIRATORY
□ CHRONIC COUGH
□ SHORTNESS OF BREATH
□ BRONCHITIS
□ ASTHMA
□ EMPHYSEMA

WOMEN
□ PREGNANT-DUE: ___
_____
□ PMS
□ MENOPAUSE

GENERAL
□ LEFT HANDED
□ RIGHT HANDED

IMMUNE SYSTEM
□ HEPATITIS
□ TUBERCULOSIS (TB)
□ HIV/AIDS
□ ALLERGIES
□ SKIN CONDITIONS
TYPE:_____
_____
□ BRUISE EASILY

MUSCLES/JOINTS
□ ARTHRITIS
□ BURSITIS/TENDONITIS
□ FRACTURES
□ WHIPLASH □ TMJ
□ NECK PAIN
□ BACK PAIN - AREA: _____
_____
□ STIFF/SWOLLEN JOINTS
□ POOR POSTURE
□ FOOT/ KNEE/ LEG PAIN
□ ARM / HAND PAIN

GASTROINTESTINAL
□ CONSTIPATION / DIARRHEA
□ LIVER/GALL BLADDER
□ ULCERS
□ NAUSEA/ HEARTBURN/ GAS

OTHER CONDITIONS
□ HEADACHES / MIGRAINES
□ VISION/ HEARING PROBLEMS
□ LOSS OF SENSATION
□ DIABETES - TYPE: _____
□ HYPOGLYCAEMIA
□ EPILEPSY
□ CANCER
□ SCIATICA
□ ARTIFICIAL JOINTS
□ INTERNAL PINS
□ SPECIAL EQUIPMENT

CURRENT MEDICATIONS & CONDITIONS
_____
_____

PAST SURGERY / INJURY DATE
_____
_____

OTHER HEALTHCARE
□ CHIROPRACTOR
□ PHYSIOTHERAPY
□ OTHER: _____

CANCELLATION POLICY

Synergy Centre has established the following missed or late cancellation policy:

It is important that you be punctual for your appointment so you may benefit from the full time slot reserved for your treatment. If you are unable to keep your appointment, please advise us 48 hours in advance to avoid late cancellation fee. We appreciate and thank you for your understanding.

CONSENT FOR TREATMENT

I have been informed and understand the purpose of the assessment and the related benefits of treatment, as well as the possible risks and side effects. I have had the opportunity to ask any questions regarding the assessment during the visit, as well as the treatment and any alternative. I understand that I have the right to have the therapist modify or stop the assessment/ treatment at any time.

I understand that all my records will be kept confidential and will not be released without my written consent. I give consent to all practitioners at Synergy Centre to read, share and discuss my personal medical history while I am a patient at Synergy Centre.

I am aware that a missed or cancelled appointment without 24 hours notice will result in a charge.

I _____ hereby consent to the assessment / treatment / cancellation policy as prescribed by my massage therapist.

_____ _____

Name: Printed Date

_____

Signature of patient / Legal guardian

CONSENT FOR TREATMENT OF SENSITIVE AREAS

Some medical conditions require treatment to sensitive areas; gluts, medial thigh, breast or abdomen. If indicated and recommended by your massage therapist, please read and sign below.

I _____ hereby consent to massage therapy for gluts, medial thigh, breast and/ or abdomen as recommended by my massage therapist. Techniques, draping, effects and risks have been explained to me. I am aware of my right to have my therapist modify my treatment or withdraw my consent at any time.

_____ _____

Name: Printed Date

_____

Signature of patient / Legal guardian

Benefit Information:

Company:_____Group#_____ID#_____