WELCOME TO YOUR MASSAGE EXPERTS EXPERIENCE!

Please fill out this form with all requested information before your treatment begins.

*** Please turn off your *mobile devices* while enjoying our surroundings ***

FULL NAME _____

BIRTHDATE MONTH / DAY / YEAR _____ GENDER _____

EMAIL ADDRESS _____

STREET ADDRESS _____

CITY / PROV / PC CITY _____ PROV. _____ POSTAL CODE _____

HOME / WORK / CELL PH# HOME _____ WORK _____ CELL _____

YOUR OCCUPATION _____ # HRS PER WEEK _____

EMERG CONTACT NAME _____ EMERG PHONE # _____

EMAIL COMMUNICATION:

Please send me appointment confirmations, reminders, and receipt emails □ Y □ N

Please add me to your marketing and offers database *(approx. 1-2/month)* □ Y □ N

**** Your email is solely used by Massage Experts and will never be given to a third party. *** You can unsubscribe to emails at any time.*

Approximate date of last therapeutic massage: _____

Have you taken an anti-inflammatory or painkiller today? *(Tylenol, Aleve, Aspirin, Advil, etc)* □ Y □ N

What prompted your visit today? *(check all that apply)*

□ Personal Health □ Injury/Pain □ Stress □ Other: _____

Are you affected by any of the following conditions? *(check all that apply)*

□ Allergies or Hypersensitivity Reactions
□ Arthritis / Bursitis
□ Asthma / Emphysema / Chronic Cough
□ Athlete's Foot
□ Cancer Where _____
□ Carpal Tunnel Syndrome
□ Crohn's / Colitis
□ Depression and/or other Mental Illness
□ Diabetes
□ Edema
□ Epilepsy
□ Fever
□ Fibromyalgia
□ Flu / Cold Virus
□ Gastro-Intestinal / Digestive Ailments
□ Headaches / Migraines
□ Hearing or Vision Loss
□ Heart Attack / Disease / Failure
□ Hepatitis A, B, or C or Herpes
□ High Cholesterol
□ High / □ Low - Blood Pressure
□ HIV / Aids
□ Infection(s) Where _____
□ Infectious Disease
□ Metal Plates / Screws / Implants
□ Neck / Spine Injury
□ Numbness / Tingling
□ Osteoporosis
□ Pacemaker or Similar Device
□ Poor Circulation
□ Pregnancy Due Date _____
□ Pregnancy Complications ***
□ Recent Surgery
□ Shingles
□ Skin Irritations / Rashes / Warts
□ Smoker
□ Sports Injury
□ Stroke / Aneurysm
□ Varicose Veins / Phlebitis

Family History of: _____ Other: _____

Are you receiving any ongoing medical care for any conditions not listed above? □ Y □ N

Explain: _____

Have you been in an automobile accident or have an injury we should know about? □ Y □ N

Explanation and date(s): _____

List of major surgeries and the date(s): _____

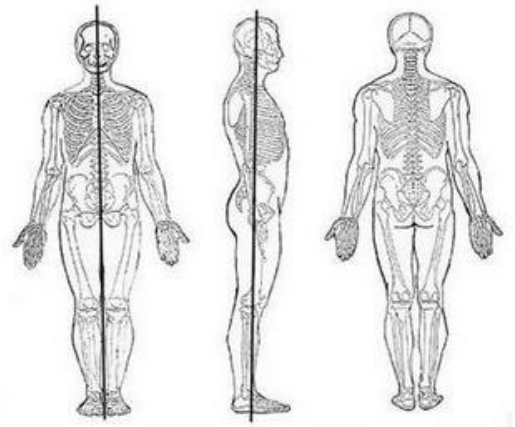
List of any current medication(s): _____

What is the primary concern or physical complaint which has brought you in today? _____

_____

_____

In what area(s) are you currently experiencing tissue, joint, or muscle discomfort?
(circle on below picture, or check all that apply)



□ Jaw □ Neck □ Shoulders □ S/Blades
□ Arms □ Hands □ Back □ Upper Back
□ Middle Back □ Lower Back □ Hips □ Glutes
□ Legs □ Knees □ Calves □ Feet

Explain: _____

Are you currently seeing any other healthcare practitioners?

□ Acupuncture □ Chiropractor □ Naturopath
□ Osteopath □ Physiotherapy □ Other

Explain: _____

Please rate your current sense of overall health and wellbeing:

□ Great □ Fair □ Average
□ Below Average □ Poor □ Other

Explain: _____

How did you hear about Massage Experts: *(Circle All That Apply)*

□ Facebook □ Google Search □ Yellow Pages □ Walk-By / drove-by □ Newspaper
□ Twitter □ Yahoo Search □ Yelp □ Mail Flyer / Postcard □ Radio
□ Instagram □ Bing Search □ Kijiji □ Sponsored Event □ Television
□ Local Gym: (Name) _____ □ Local Business: (Name) _____
□ Physician: (Name) _____ □ Friend: (Name) _____

Please read and acknowledge by signing the below:

- ✓ You are expected to be punctual as your treatment time(s) have been specifically reserved for you and will not be extended.
- ✓ You understand that all appointment times include a pre-health assessment or health consultation, as well as appropriate change time.
- ✓ Please advise your Massage Therapist on whether the pressure is sufficient or too strong. A massage is always customized to you.
- ✓ To the best of your knowledge the above information is true and is the most up-to-date information you can give the attending massage therapist.
- ✓ As your health status changes, you will advise us, so that we may update your file. Failure on your part to disclose any health information could possibly result in an injury and/or illness, and you hereby release Massage Experts from any claims resulting as such.
- ✓ You authorize Massage Experts to contact the above doctor or health-related specialist if required for treatment purposes.
- ✓ You understand that this information given is confidential, unless required by law, and will only be released with your written consent.
- ✓ Your information will not be used for any other purpose than to assist your massage therapist in providing you with a personalized and safe massage which will take into consideration your individual health requirements.
- ✓ The information provided to you by your massage therapist is for general purpose only and is not intended for any medical diagnosis.
- ✓ It is by your free-will that you are receiving this massage therapy today and in future visits.
- ✓ **You understand that your therapist can terminate treatment at any point due to inappropriate or suggestive behaviour.**
- ✓ **You understand that 24-hours' notice is required to cancel or reschedule all appointments, or full charges will apply.**

SIGNATURE: _____ **DATE:** MO/DA/YEAR _____

Dated:	**OFFICE USE ONLY: Description of Health Changes, If Any:**	**Client Initials:**
MO/DA/YEAR		
MO/DA/YEAR		
MO/DA/YEAR		
MO/DA/YEAR		