CURAVITA
Chiro • Massage • Physio

CONFIDENTIAL MASSAGE CASE HISTORY

Legal Name: _____ Date: _____

How do you wish to be addressed in our office? _____

Address: _____ Postal Code: _____

Phone: _____ Date of birth: dd ____ mm ____ yr____ email:_____

Bus. phone: _____ Occupation: _____ Chiropractor's name: _____

MD name: _____ Referred by: _____

Emergency contact name: _____ Phone: _____

Are you seeking massage for relaxation? ☐Yes ☐No Do you have a specific complaint? Please explain:_____

_____

How would you describe your general health status? _____

Have you ever seen a massage therapist before? ☐Yes ☐No If yes, last visit date? _____

Please indicate conditions you are experiencing, or have experienced:

Are you interested in strategies to help you continue to feel well or even better? ☐Yes ☐No

Do you now or have you ever had any of the following...

Respiratory
- ☐ Chronic cough
- ☐ Shortness of breath
- ☐ Bronchitis
- ☐ Asthma
- ☐ Emphysema

Other Conditions
- ☐ Diabetes (onset: _____)
- ☐ Allergies (anaphylaxis)
- ☐ Skin irritations
- ☐ Epilepsy
- ☐ Cancer
- ☐ Arthritis
- ☐ Any family history of Arthritis

Gynecological Conditions
- ☐ Describe:

_____
_____
_____
_____

Pregnant: Yes☐ No☐
Due date: _____

Cardiovascular
- ☐ High blood pressure
- ☐ Low blood pressure
- ☐ Chronic congestive heart failure
- ☐ Heart attack
- ☐ Phlebitis
- ☐ Stroke/CVA
- ☐ Pacemaker or similar device
- ☐ Heart disease

Infections
- ☐ Hepatitis
- ☐ Skin conditions
- ☐ TB
- ☐ HIV

Head/Neck
- ☐ Vision problems
- ☐ Vision loss
- ☐ Ear problems
- ☐ Hearing loss
- ☐ Dizziness
- ☐ Headaches
- ☐ Migraines

Current medication and condition it treats: _____

Surgery, dates: _____

Injury, dates: _____

Present involvement in other Health Care: ☐Yes ☐No If yes, please specify: _____

Other medical conditions: (eg. depression, digestive, hemophilia, mental illness, osteoporosis, etc.) _____

_____

Of special note: (presence of internal pins, wires, artificial joints, special equipment) _____

_____

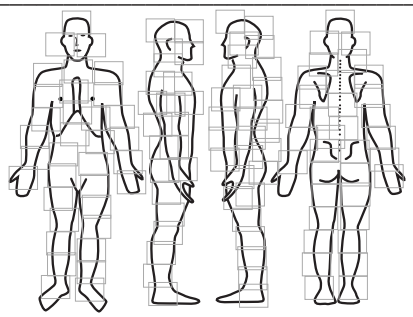
Are you currently experiencing any of the following....

Pain: ☐Yes ☐No What type? (dull, sharp, shooting...)
Where? Circle areas on body diagram below

Stiffness: ☐Yes ☐No What type? (Muscle, skin, joint...)
Where? Indicate with an X on diagram below

Numbness: ☐Yes ☐No What type? (tingling, lack of sensation...)
Where? Indicate with ////// on diagram below

Previous occurrence of above symptoms? ☐Yes ☐No



Front Right Left Back

An accurate health history is important to ensure that it is safe for you to receive a massage treatment. If your health status changes in the future, please let us know.

All information gathered for this treatment is confidential.

You will be asked to provide written authorization for release of any information. Our privacy statement is available upon request. If you have any questions or concerns, please contact our privacy information officer.

Fee Schedule

One hour massage	**$110.00 + hst**

Payment is due at the time of service and we will provide you with a receipt you can submit to your insurance company for possible reimbursement.

Cancellation Policy

To avoid charges, please provide a minimum of 12 hours notice for cancellation. A 100% cancellation fee will be charged if you cancel your appointment with less than 12 hours notice or if you do not show for your scheduled appointment time.

If your appointment is booked on the same day, please be aware that the cancellation policy will be in effect once your appointment is set. This is done in fairness both to clients who would otherwise have wanted the appointment as well as the therapist, who is not paid if they do not perform the session.

We take pride in the fact that our clients never wait and are never rushed. As a courtesy to everyone, thank you for being prompt. Late arrivals can only be extended to the time remaining in their scheduled session.

I consent to the clinic to communicate electronically with me for the purpose of scheduling appointments, appointment confirmations, clinic updates and newsletters. ☐ Yes ☐ No

_____

Client Signature (or Parent/Guardian)

_____

Dated

The client always has the right to modify, terminate or refuse treatment at any time regardless of prior consent given. If you have any questions about any aspect of massage therapy or specifics of your treatment, feel free to ask your massage therapist.

Please be a responsible mobile phone user by being considerate to others while in our clinic.