Wolseley Wellness Centre

Patient History and Consent to Treatment

Name:________________________________ Today's Date: D________/M________/Y_______

Address:________________________________ Phone Number:________________________________

City/Province:________________________________ Postal Code:________________________________

E-mail:________________________________ Date of Birth:_______/_________/____________

Emergency Contact:__________________________

Referred By:________________________________

Have you received massage therapy before? □ yes □ no Last visit:__________________________

What is your occupation?____

What is your level of:

Work stress:	none	low	moderate	high	Caffeine intake:	none	low	moderate	high
Overall stress:	none	low	moderate	high	Water intake:	none	low	moderate	high
Exercise level:	none	low	moderate	high	Alcohol intake:	none	low	moderate	high
Sleep quality:	none	low	moderate	high	Energy:	none	low	moderate	high

What physical activities do you enjoy:____

How do you relieve stress: ____

List any medications/supplements you currently use - include prescription and non-prescription drugs:

____

____

Do you have any allergies □ yes □ no

____

____

Are you currently pregnant □ yes □ no If so, due date:___/___/_____

Complications: ____

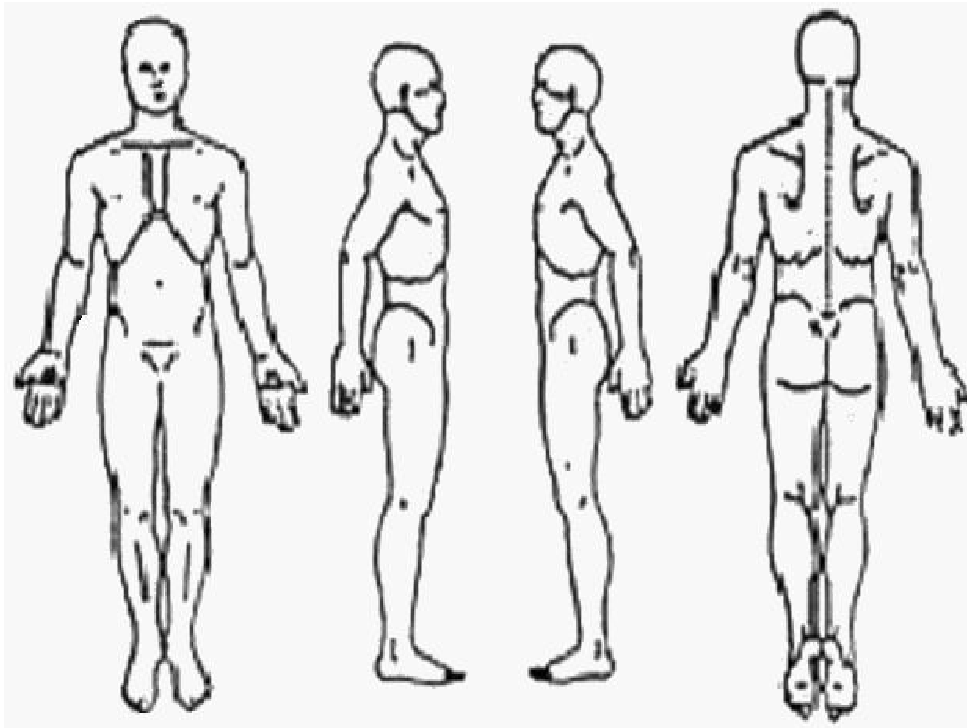
Please check ( ) any conditions you currently have, or ever had:

( ) Hearing impairment
( ) Visual impairment
( ) Motor vehicle accident
( ) Work sport injury
( ) Surgery
( ) Medical implants
( ) Migraines/headaches
( ) Chronic pain
( ) Breast/chest pain
( ) Bone fracture
( ) Diabetes
( ) Infectious condition (hepatitis, HIV, flu, shingles)
( ) Cardiovascular condition (hypertension, hypotension)
( ) Respiratory condition (asthma, bronchitis)
( ) Endocrine condition (hyperthyroidism, hypothyroidism)
( ) Neurological condition
( ) Psychological condition (depression, anxiety, PTSD)
( ) Skin condition (eczema, psoriasis, etc)
( ) Bone or joint condition (arthritis, osteoarthritis, osteoporosis)
( ) Digestive condition (IBS, constipation)
( ) History of tumorous condition or cancer
( ) Other:____

What is your reason for today's visit? (please check all that apply)

( ) Wellness ( ) Stress ( ) Relaxation ( ) Pain ( ) Injury

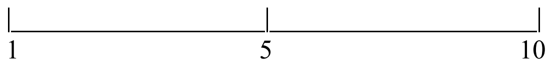
Please mark any areas of complaint:



( ) Cramping or aching
( ) Tingling or numbness
( ) Heat, burning or stinging
( ) Sharp or shooting
( ) Deep, nagging or dull
( ) Throbbing or diffuse

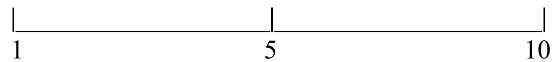
When is the pain more dominant:
( ) Morning
( ) Day
( ) Night

Scale your pain today:



1 5 10

Scale pain at its worse:



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Notes:____

I, ______________________________ state that the information provided is accurate to the best of my knowledge and understand that the information will be kept confidential. I understand that massage therapy is not a substitute for medical treatment, that certain conditions cannot be treated and may be out of the scope of practice, and that I may be refused certain services. I understand that I shall seek medical attention for any ailments I may have and the therapist shall not be held responsible for any condition that does not have visible signs to which they may be aware. I agree to inform the therapist of any new conditions that may arise in the future.

Signature:____________________________ Date:____________________________