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### Client Health History Form

For your health:

An accurate health history is important to ensure that you receive a safe massage treatment. If your health status changes in the future, please let me know. All information gathered for this treatment is confidential except as required by law or except to facilitate assessment and treatment. You will be asked to provide written authorization for release of any information.

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Name: \_\_\_\_\_

Date: \_\_\_\_\_

Address: \_\_\_\_\_

Tel: Res: \_\_\_\_\_

\_\_\_\_\_

Bus: \_\_\_\_\_

\_\_\_\_\_

Date of Birth (D/M/Y): \_\_\_\_\_

Fax/email: \_\_\_\_\_

Occupation: \_\_\_\_\_

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What brings you in for massage? \_\_\_\_\_

Cause (If known): \_\_\_\_\_

Are you being treated for this? \_\_\_\_\_

How did you hear of our clinic? (Dr. / sign / massage therapy client...) \_\_\_\_\_

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Your Physician's name and number: \_\_\_\_\_

May he/she be contacted about your treatment? \_\_\_\_\_

Emergency contact: \_\_\_\_\_

Their number: \_\_\_\_\_

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## Health History Information

Do you exercise regularly? Y / N

Frequency: \_\_\_\_\_

Duration: \_\_\_\_\_

Please indicate conditions that you are currently experiencing, or have experienced in the past.

### Head/Neck

- Headaches
- Type \_\_\_\_\_
- Vision problems
- Contact lenses
- Earaches

### Respiratory

- Chronic cough
- Shortness of breath
- Smoking
- Asthma
- Bronchitis
- Emphysema

### Cardiovascular

- High blood pressure
- Low blood pressure
- Poor circulation
- Heart disease
- Phlebitis
- Stroke, date \_\_\_\_\_
- Varicose veins
- Arteriosclerosis
- Heart Attack  
Date: \_\_\_\_\_
- Pacemaker or Similar Device
- Chronic Congestive Heart Failure

### Skin

- Bruise easily
- Skin Conditions
- Type \_\_\_\_\_

### Arthritis

- Rheumatoid Arthritis  
Where \_\_\_\_\_
- Osteoarthritis  
Where \_\_\_\_\_
- Dr. Diagnosed? Y / N
- Other \_\_\_\_\_

### Other conditions

- Difficult digestion
- Constipation
- Liver
- Gall bladder
- Kidney
- Epilepsy
- Diabetes, onset \_\_\_\_\_
- Sinus
- Allergies
- Insomnia
- Cancer

### Muscles/Joints

- Neck stiffness/pain
- Low back stiffness/pain
- Mid back stiffness/pain
- Upper back stiffness/pain
- Degenerative discs
- Arm pain / tingling / injury
- Hip or thigh pain
- Knee pain
- Leg / foot pain
- TMJ / jaw / tooth pain
- Repetitive strain / work injury
- Tendinitis
- Bursitis
- Fracture
- Fibromyalgia

### Female

- Menstrual Problems
- If So, Painful? Y / N
- Pregnant Due \_\_\_\_\_
- Caesarian Section or other
- Gynecological Surgery
- Children: Number \_\_\_\_\_
- Menopausal Problems

Any Medications / Homeopathic / Naturopathic / Supplements and for what condition(s)

\_\_\_\_\_  
\_\_\_\_\_

### Surgery

Type \_\_\_\_\_  
Date \_\_\_\_\_  
Current Symptoms \_\_\_\_\_  
\_\_\_\_\_

### Injury

Type \_\_\_\_\_  
Date \_\_\_\_\_  
Current Symptoms \_\_\_\_\_  
\_\_\_\_\_

### Other Healthcare

- Chiropractic
- Physiotherapy

Other medical conditions / concerns: \_\_\_\_\_

Client Name: \_\_\_\_\_ Date: \_\_\_\_\_

At any time during or before the massage, you can choose to alter or stop the treatment. If you have any questions or concerns about massage therapy or your treatment, please talk to your therapist.

During the treatment, you will be draped (covered) with sheets. The draping will only uncover the area being worked on at the time. You may choose to remove or leave on clothing according to your level of comfort.

You may experience some soreness, discomfort, or a headache the day after your massage. If this happens, it is important to let the therapist know so that your next treatment can be modified. Your therapist will have suggestions on how to prevent the discomfort from occurring.

**We require 24 hours notice when canceling or rescheduling an appointment. In the event of a missed appointment, you will be charged half of the regular price for the scheduled appointment.**

- I have fully disclosed all medical conditions that I am aware of, and understand that it will be my responsibility to inform my therapist of any changes in my health status.
- I acknowledge that this information is confidential, and that no personal data shall be released to anyone (following the laws of confidentiality).

I have read the above information fully and wish to proceed with the treatment.

Signature of Client: \_\_\_\_\_ Date: \_\_\_\_\_