peak massage therapy

The information requested assists Peak Massage Therapy in providing a safe and effective massage therapy treatment. All of the information provided will be kept confidentially unless permission is granted or if required by law. Your written permission will be required to release any information.

Name_____ **Date of Birth (D/M/Y)**_____
Address_____ **Postal Code**_____
Phone Number_____
E-Mail_____
Primary health care physician_____ **Office**_____
Phone_____
Were you referred for massage therapy? **YES** **NO** If yes, by whom?_____
Please list any current medications or supplements, and for what conditions:_____
Please list any surgical procedures, and dates they occurred:_____
Do you have any injuries, please include dates:_____
Do you have any internal pins, wires, artificial joints or special equipment? If yes, please provide details of location and type:
_____

Cardiovascular: ☐ High / low blood pressure (*circle one)* ☐ Chronic congestive heart failure ☐ Heart attack / stroke / CVA (*circle one)* ☐ Phlebitis / Varicose veins (*circle one)* ☐ Heart disease: _____	**Respiratory:** ☐ Chronic cough ☐ Shortness of breath ☐ Bronchitis ☐ Asthma ☐ Emphysema	**Head/Neck:** ☐ Headaches / migraines (*circle one)* ☐ Impaired vision ☐ Impaired hearing ☐ Dizziness
General: ☐ Tingling / numbness / loss of sensation ☐ Epilepsy ☐ Arthritis / Osteoporosis / RA ☐ Allergies / hypersensitivities ☐ Scoliosis: _____ ☐ Diabetes ☐ Cancer	☐ Hepatitis ☐ HIV ☐ Herpes ☐ Irritable skin condition ☐ Contageous skin condition ☐ TB ☐ Influenza	☐ Anxiety ☐ Depression ☐ Other condition not listed *(please provide a brief description below)* _____

Is there a family history of any of the above, if yes please specify:_____
What is your general health status: _____
Have you ever received massage therapy before? **YES** **NO** If yes, when was your last treatment?_____

WOMEN
Are you pregnant? **YES** **NO** If yes, what trimester, and when is your due date?_____

Consent to treatment
The information above is complete and accurate to the best of my knowledge. I understand that it is my responsibility to inform the therapist of any changes to my health. I understand that I may withdraw consent to my treatment or request changes to the treatment at any time before or during the treatment. I understand the fee schedule and that any cancellations made less than 24 hours to a scheduled appointment will require an $80 charge. I give my consent to receive treatment.

_____ _____
Signature Date