Carp Ridge EcoWellness Centre

Client Case History Form

The information on this form is confidential and can only be discloses with the client's written permission or for a court of law. It is important that the information is correct and up-to-date to ensure a safe treatment.

Name: ______________________________ TEL: (H) ________________________

Address: ____________________________ (W) ________________________

____________________Postal Code: ___________Date of Birth (d/m/y) __________

Email:______________________________

What brings you in for a massage? _____________________Occupation:___________

How did you hear of our services? (Dr, friend, brochures…) ________________________

May we contact them about your treatment? YES / NO

May other therapists at Carp Ridge have access to your file, if needed? YES / NO

Health History: Please indicate conditions that you are currently experiencing or have experiences often in the past.

Head/Neck	Skin	Other Conditions
__ Headaches	__ Bruise easily	__ Difficult digestion
Type ___________________	__ Skin conditions	__ Constipation
__ Vision problems	Type _______________	__ Liver
__ Contact Lens		__ Gall bladder
__ Earaches	Arthritis	__ Kidneys
	__ Rheumatoid Arthritis	__ Epilepsy
Respiratory	Where ________________	__ Diabetes, onset ____________
___ Chronic cough	__ Osteoarthrosis	__ Sinus
__ Shortness of breath	Where ________________	__ Allergies
__ Smoking	Dr. Diagnosed? Yes / No	__ Insomnia
__ Asthma	__ Other _________________	__ Cancer
__ Bronchitis/Emphysema		
	Female	Muscles/Joints
Cardiovascular	__ Menstrual problems	__ Neck stiffness /pain
__High or low blood pressure	If so painful? Yes No	__Back stiffness / pain / injury
__Chronic congestion heart failure	__ Pregnant, Due _________	__ Degenerating discs

Poor circulation	__ Caesarian section or other gynecological surgery	__ Arm pain / tingling / weakness
__ Heart disease	____________________________	__ Hip or thigh pain
__ Phlebitis	__ Children: Number _______	__ TMJ / jaw / tooth pain
__ Stroke, date: _______________	__ Menopausal problems	__ Sports injury
__ Varicose veins	___________________________	__ Repetitive Strain / Work injury
__ Arteriosclerosis		__ Tendinitis
__ Heat attack, date ____________		__ Bursitis
		__ Fracture
		__ Fibromyalgia

Medications

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Surgery	**Injury**	**Other Healthcare**
Type	Type	__ Chiropractic
Date_________________________	Date ________________________	__ Physiotherapy
Current Symptoms _____________	Current Symptoms _____________	__ Regular Exercise
_____________________________	_____________________________	__ Other _____________________

Other Medical Conditions/Concerns

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At any time during the massage, you can choose to stop or modify 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 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 or discomfort 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 cancelling or rescheduling an appointment. You will be charged in the event of a missed appointment.

I have read and understood the above and agree to massage therapy treatment.

Signature ____ Date _____________________