The Walnut Tree
Massage Therapy & Wellness

CONFIDENTIAL CLIENT HEALTH HISTORY FORM

Today's date: _____

First name: _____ Last name: _____

Date of birth: _____

Address: _____

City, Province, Postal code: _____

Home phone: _____ Mobile phone: _____

Email: _____

Allergies: _____

Do you have any surgically implanted plates/pins/screws? Y or N

If so, where? _____

Have you had massage before? Y or N How was your experience? _____

Occupation: _____ Sports/Hobbies: _____

Physician: _____ Physician's phone: _____

Medications/vitamins currently taken: _____

Other healthcare currently received: _____

Emergency contact name and phone: _____

How did you hear about The Walnut Tree? If someone referred you, what is their name?

_____

Do you wish to receive The Walnut Tree's seasonal promotions via email (if so, please provide email address above)? Y or N

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

SKIN
- ☐ rash
- ☐ bruise easily
- ☐ infectious skin condition(s):

_____

- ☐ other:

_____

MUSCLES/JOINTS
Indicate left (L) or right (R) where applicable
- ☐ neck
- ☐ upper back
- ☐ mid back
- ☐ lower back
- ☐ shoulder
- ☐ elbows
- ☐ arm
- ☐ wrist
- ☐ hand
- ☐ hip
- ☐ leg
- ☐ knee
- ☐ ankle
- ☐ foot
- ☐ weakness/loss of strength
- ☐ clumsiness
- ☐ osteoarthritis
- ☐ rheumatoid arthritis
- ☐ other arthritis:

_____

- ☐ osteoporosis
- ☐ tendinitis
- ☐ muscle strain
- ☐ joint sprain/dislocation:

_____

- ☐ other injury:

_____

_____

_____

RESPIRATORY
- ☐ asthma
- ☐ bronchitis
- ☐ chronic cough
- ☐ difficulty breathing
- ☐ emphysema
- ☐ shortness of breath
- ☐ other:

_____

CARDIOVASCULAR
- ☐ bleeding disorder
- ☐ high blood pressure
- ☐ low blood pressure
- ☐ heart attack
- ☐ heart disease
- ☐ angina
- ☐ stroke
- ☐ pacemaker
- ☐ varicose veins
- ☐ phlebitis
- ☐ other:

_____

HEAD/NECK
- ☐ visual impairment
- ☐ hearing impairment
- ☐ speech impairment
- ☐ headaches or migraines
- ☐ jaw pain (TMJD)
- ☐ sinus problems
- ☐ other:

_____

GI CONDITIONS
- ☐ constipation
- ☐ diarrhea
- ☐ IBS
- ☐ hiatus hernia
- ☐ ulcers
- ☐ other:

_____

VARIOUS
- ☐ kidney disease
- ☐ diabetes type: _____
- ☐ fainting/dizziness
- ☐ fibromyalgia
- ☐ insomnia
- ☐ numbness/tingling
- ☐ cancer
- ☐ seizures
- ☐ chronic fatigue

WOMEN
- ☐ menstrual problems
- ☐ menopausal problems
- ☐ gynecological condition(s)
- ☐ pregnant
  Due date: _____

INFECTIOUS CONDITIONS
- ☐ hepatitis: _____
- ☐ HIV/AIDS
- ☐ cold sores
- ☐ tuberculosis
- ☐ other:

_____

FRACTURE
☐ No ☐ Yes

_____

_____

SURGERY
☐ No ☐ Yes

_____

_____

MOTOR VEHICLE ACCIDENT
☐ No ☐ Yes

_____

_____

Informed Consent for Massage Therapy Treatments

- I attest that the information I have provided on this form is true and complete to the best of my knowledge. I understand that the information I provided is confidential and will not be released without my written consent.
- I understand that a 24-hour notice is required to cancel or reschedule all future appointments, otherwise full charges for the missed treatment may apply. I also understand that arriving late may result in my appointment time being shortened to avoid delaying the next client (and that full charges will apply).
- I understand that massage therapists do not diagnose illnesses, physical/mental disorders, or prescribe medications. I understand that massage therapy is not a substitute for medical care or treatment. I understand that the Registered Massage Therapist is providing massage therapy services within their scope of practice and code of ethics as defined by the Massage Therapist Association of Alberta.
- I understand there may be some side effects from treatment, which can be, but are not limited to, aching or stiffness, soreness, headache, nausea, fatigue, and/or bruising. I also understand that the therapist may give me homecare so I can take care of myself at home to enhance the effects of the massage and minimize these side effects.
- I acknowledge and understand that the therapist must be made fully aware of any existing medical conditions and I have made an effort to alert the therapist of such. I have disclosed all medications (including vitamins) that I am currently taking. I take it upon myself to update the massage therapist regarding any changes in my mental, emotional, or physical health status (current and in the future).
- I understand that certain medical conditions need doctor's permission to proceed with massage therapy treatment. If I have a medical condition, I understand that I should first speak to the Registered Massage Therapist and, if needed, get a doctor's note prior to my first appointment.
- I am aware that this work is performed directly on the skin with the use of lubricants and that all areas of my body not being treated will remain draped. Client privacy and respect will be assured at all times. The client may choose to be clothed (noting that there will be limitation in massage techniques) or undressed to their comfort level and be draped throughout the treatment. I also understand that the lubricant may stain any clothing that I choose to keep on during treatment.
- I have the right to refuse, modify, or terminate treatment at any time for any reason. I agree to communicate with my massage therapist if, at any time, I feel my wellbeing or comfort level is compromised. I also have the right to ask questions about the treatment throughout the session.
- The massage therapist reserves the right to reject clients and end massage treatments at any time. Reasons can be, but are not limited to, health concerns, conditions that contraindicate massage, insufficient health information provided, and/or inappropriate client behaviour.
- Sexual misconduct in any form will not be tolerated. Any comments or actions implying to such will result in immediate termination of the session and the client will be required to pay for the treatment in full.
- I release The Walnut Tree Massage Therapy & Wellness Inc., its massage therapists, and staff from any liability, past, present, and future, relating to treatment received at this clinic.

By signing this form, I agree that I have thoroughly read and understand the above. I give explicit consent for treatment.

_____ _____

(client's signature) (client's printed name)

_____

(today's date)