

Royal York Massage Therapy

4237 Dundas St. W., Etobicoke, ON. M8X 1Y3 (416) 233-5413 Fax: (416) 233-1532

-Health History Form-

Name: _____ Home Tel: _____

Address: _____ Apt. #: _____ 2nd Tel: _____ Cell
Work
ext: _____

City: _____ Postal Code: _____ Date of Birth (dd/mm/yr): ____/____/____

Occupation: _____ Is this your first massage therapy session? Yes No

Email: _____

Referred by: Yellow Pages or Other if so then how/whom? _____

What is your Primary Concern or what is/are you Massage Therapy goal(s): _____

Primary Health Care Physician or Doctor: Name: _____ M.D. D.C. N.D. Other: _____

Address: _____ City: _____ Tel: _____

Cancellation Policy

- ◆ The treatment and/or services you select are reserved especially for you. To respect both the therapist's time and others in the community who request our services we require 24 hours notice of appointment cancellation. This allows us sufficient time to schedule other clients requesting appointments and therapists to make appropriate changes to there schedule.
- ◆ Appointments cancelled with less than 24 hours notice will be charged a full fee. The only exceptions will be due to extreme circumstances which can be discussed with your therapist.
- ◆ Appointments that are cancelled without any notification, or simply not showing for your appointment, will result in a full fee being charged to your account and a credit card number may be required to guarantee future bookings.
- ◆ Late arrivals will lose the time they have missed and your appointment will end as scheduled.

I, _____, understand the above cancellation policy and I will discuss any concerns with the therapist.

Signed: _____ Date: _____

Health History: Please indicate with an **X** which of the following you are currently experiencing or have previously experienced.

Muscle & Joint Concerns

- Neck
- Shoulder
- Upper Back
- Mid Back
- Low Back
- Arms
- Legs
- Knees
- Hips
- Other: _____

Cardiovascular

- High Blood Pressure
- Low Blood Pressure
- Heart Attack
- Phlebitis
- Stroke/CVA
- Pacemaker
- Heart disease
- Angina
- Chronic Congestive Heart Failure

Other Concerns

- Neurological conditions
- Epilepsy
- Diabetes
Type: _____
- Onset: _____
- Allergies
- Anaphylaxis
- Cancer
- Arthritis
Type: _____
- Areas: _____

Head

- Tension headaches
- Migraines
- Tooth/jaw/ear pain
- Head trauma
- Other: _____

Infectious Disease

- Hepatitis
- Tuberculosis
- HIV
- Other: _____

Perinatal

- Pregnant
Due Date: _____
How many children: _____

Respiratory

- Chronic cough
- Shortness of Breath
- Bronchitis
- Asthma
- Emphysema
- Pneumonia
- Sinus problems

Skin

- Skin Condition
Specify: _____
- Bruise easily
- Herpes
- Varicose veins
- Athletes foot
- Loss of Sensation
- Areas: _____

Please list Current Medications:

-
-
-
-
-

What is your general health status: _____

<p>Please list any accidents, injuries, falls and/or breaks:</p> <ul style="list-style-type: none"> • _____ Date: _____ • _____ Date: _____ • _____ Date: _____ • _____ Date: _____ 	<p>Please list any surgeries:</p> <ul style="list-style-type: none"> • _____ Date: _____ • _____ Date: _____ • _____ Date: _____ • _____ Date: _____
<p>Please list any pins, wires, staples, plates and/or prosthetics:</p> <ul style="list-style-type: none"> • _____ 	

Other Medical Conditions or comments: