



## Registered Massage Therapy - Medical History Form

CONFIDENTIAL

**Please check boxes, circle or fill in where applicable**

To assist in providing you with the best possible care, please fill in this form as accurately as you can. All of the information will be kept confidential in your patient file.

Today's Date: \_\_\_\_/\_\_\_\_/\_\_\_\_  
month day year

Name: \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_  
Last Name First Name Middle Initial

Address: \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_  
Apt#, Street City Province Postal code

Phone: (home) \_\_\_\_\_

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

Phone: (work) \_\_\_\_\_

Birth Date (MDY): \_\_\_\_/\_\_\_\_/\_\_\_\_

Phone: (cell) \_\_\_\_\_

E-mail \_\_\_\_\_

Physician's Name: \_\_\_\_\_ Phone: \_\_\_\_\_

Previous Therapies:  Massage Therapy  Physical Therapy  Chiropractic  Other

1. \_\_\_\_\_

2. \_\_\_\_\_

Practitioner's Name

Last Visit

How did you hear about massage being offered at this clinic \_\_\_\_\_

What condition or area would you like treated? \_\_\_\_\_

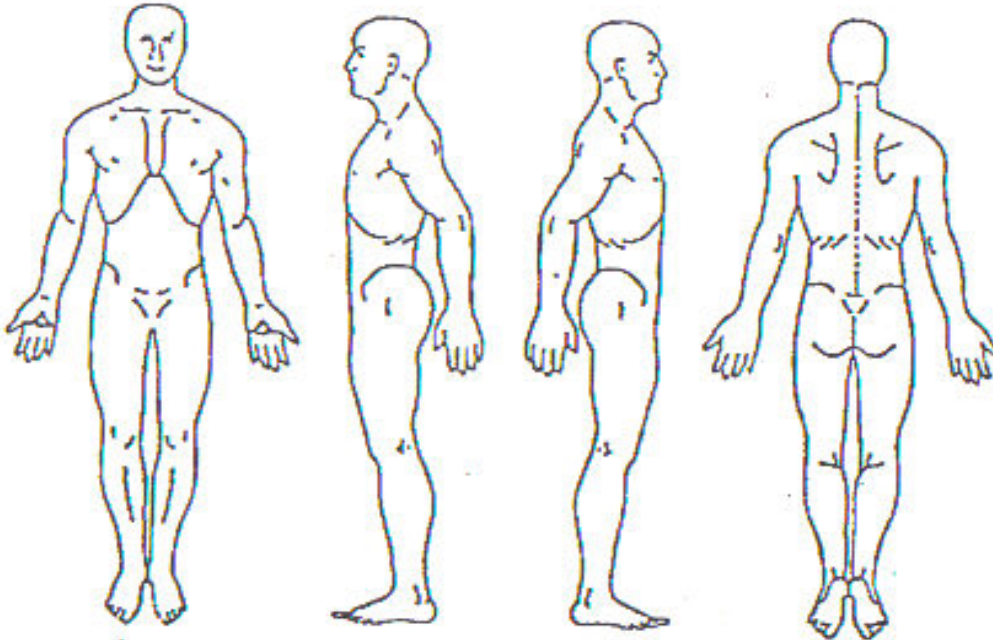
Please list any major surgeries, injuries, and/or accidents: \_\_\_\_\_

Please list any medications you are currently taking: \_\_\_\_\_

PLEASE CHECK ANY OF THE FOLLOWING CONDITIONS THAT APPLY TO YOU:

- |   |   |   |
|---|---|---|
| <input type="checkbox"/> Headaches        | <input type="checkbox"/> Abdominal Problems     | <input type="checkbox"/> Bruises Easily |
| <input type="checkbox"/> Dizziness        | <input type="checkbox"/> Acute Inflamed Areas   | <input type="checkbox"/> Plates or Pins |
| <input type="checkbox"/> Loss of Sleep    | <input type="checkbox"/> Varicose Veins         | <input type="checkbox"/> Allergies      |
| <input type="checkbox"/> Numbness         | <input type="checkbox"/> Heart Condition        | <input type="checkbox"/> Cancer         |
| <input type="checkbox"/> Nausea           | <input type="checkbox"/> Loss of Skin Sensation | <input type="checkbox"/> Respiration    |
| <input type="checkbox"/> Neck / Backaches | <input type="checkbox"/> Skin Disorders         | <input type="checkbox"/> Diabetes       |
| <input type="checkbox"/> Arthritis        | <input type="checkbox"/> High Blood Pressure    | <input type="checkbox"/> Other _____    |

On the figures below, Please circle any areas of pain/concern:



**Patient Advisory and Office Fee Policy**

During or after a massage therapy treatment certain side effects, although rare, may result. These could include, but are not limited to: pain or discomfort, and the possible aggravation of symptoms existing prior to treatment. No guarantees concerning its effects are given and you are free to refuse treatment at any time.

By signing below, I do hereby voluntarily consent to be treated by a Registered Massage Therapist at BodaHealth™.

**45 Minutes: \$65**

**60 Minutes: \$85**

**120 Minutes: \$120**

Missed Appointment Fee:

**PATIENTS WILL BE CHARGED FOR ANY MISSED APPOINTMENTS NOT CANCELLED 24 HOURS PRIOR TO THE APPOINTMENT TIME.**

PATIENT'S SIGNATURE: \_\_\_\_\_ Date: \_\_\_\_\_