CONFIDENTIAL CLIENT HISTORY

Name: _____ Date: _____

Address: _____ City: _____ Prov: _____ Postal Code: _____

Telephone: Home: _____ Work: _____ Cell: _____ E-mail: _____

Birth date: _____ Age: _____ Marital Status: M S W D

Occupation: _____ Family Physician: _____

Referred By: _____ Hobbies: _____

1. Have you had previous massage therapy? Yes_____ No _____

   If yes, name of attending practitioner _____ Date of last treatment _____

2. Are you presently receiving other treatment modalities? ie: Physical Therapy, Chiropractic Yes____ No ____

   If yes, please specify _____ Name of practitioner _____

3. Are you presently utilizing any type of physical aid or appliance? ie: prosthesis, mouth guard, orthotics

   If yes, please specify_____

4. What is your reason for having massage therapy?

   Relaxation _____ Other _____ (please specify) _____

5. Do you have pain, stiffness or other symptoms in any of the following?

	Severe	Mild			Severe	Mild	
Neck	____	____		Hips	____	____	R or L
Headaches	____	____	location _____	Legs	____	____	R or L
Upper back	____	____	R or L or Centre	Knees	____	____	R or L
Lower back	____	____	R or L or Centre	Ankles	____	____	R or L
Tail bone	____	____		Feet	____	____	R or L
Shoulders	____	____	R or L or both	Heart	____	____	Pacemaker / Attacks (circle)
Arms	____	____	R or L or both				Date_____
Elbows	____	____	R or L or both	Abdomen	____	____	
Hand	____	____	R or L or both	Digestive			
Chest	____	____	R or L or Centre	Disturbances	____	____	
Ribs	____	____	R or L				

6. Do you have any health concerns other than your present symptoms? Yes _____ No _____

   If yes, please explain _____

7. Are you presently pregnant? Yes _____ (# of wks ____) Due date _____

   Do you have any pregnancy related concerns or issues? _____

8. Are you taking any medications? Yes_____ No _____

   If yes, please specify type and reason for taking _____

9. Surgical operations:	Approximate Date		Approximate Date
Spinal surgery	_____	Hysterectomy	_____
Appendix	_____	Kidney Stones	_____
Cesarean Section	_____	Other	_____
Gall Bladder	_____		_____

10. Have you ever been hospitalized for any other reason? Yes _____ No _____

If yes, please explain _____

11. Have you had any significant accidents or injuries? ie: motor vehicle, falls Yes ____ No ____

If yes, please specify _____

12. Have you been treated for any psychological concerns? ie: depression Yes _____ No _____

Do you or have you experienced anxiousness and/or panic attacks? Yes _____ No _____

13. Date of last: Complete physical exam _____ Heart exam _____ MRI _____ EMG_____

X-ray _____ Blood pressure check _____ CT Scan _____

CONSENT FOR TREATMENT

I _____hereby authorize a therapist(s) within Myo-Therapies/.S.T.M.C. Ltd. to engage in examination, assessment, and consultation and to commence necessary treatment of me or upon me with respect to any Musculo-Skeletal conditions and/or associated bodily concerns presented by me . I understand treatment modalities may include Remedial Massage Therapy, Myofascial Release Therapy(s), CranioSacral Therapy(s), Muscle Energy Technique(s), Infant Massage Therapy, Bio-mechanical re-education, Re-habilatative Ball Therapy and applicable stretching(s) but may not be limited to. I further understand the applied modality(s) of treatment are not an exact science and results may vary with no guarantee for results being given. I under-stand some risks may be associated with applied treatment. Therapeutic discomfort may be experienced during and following treatment and possible emotional changes may occur during and following treatment.

I acknowledge the therapist(s) within Myo-Therapies/S.T.M.C. Ltd. are registered with the Massage Therapist Assoc. of Saskatchewan and have been specifically trained in the application(s) of varying treatment modalities as instructed by qualified professionals. I reserve the right to voice questions or concerns about my condition or the treatment of such, and further reserve the right to stop treatment at any time.

I have completed the confidential history to the best of my knowledge and have enclosed all relevant medical information pertaining to my health, currently and previously. Changes to my health and/or condition(s) will be forwarded as they occur. I authorize the release of or forwarding of such pertinent information to my physician and/or other respective health care professionals.

I release the aforementioned practitioner(s) from any claims, whether in contract or in tort or otherwise for loss, damages or injury to any person or property suffered by me as a result of the treatment received by me, notwithstanding that such loss, damages or injury may have arisen by reason of the negligence of this practitioner(s).

Myo-Therapies/Saskatoon Therapeutic Massage Centre reserves the right to charge the applicable 1 hour treatment fee for missed or cancelled appointments if 24rs notice has not been received.

* Client _____ Date _____

Clients Legal Guardian (if under 18 years old) _____

Parents and/or legal guardians of clients under 16 years of age are required to be present in the treatment room during all treatments and or consultations. **No Exceptions.**
Clients between 16 and 18 years of age require written consent prior to commencing treatment and or consultations.