TYMOTHY ROY
WELLNESS

GENERAL INFORMATION

Name: _____ Gender: **M / F**

Date of Birth: _____ Occupation: _____

City: _____ Province: _____ Postal Code: _____

Telephone: Home: _____ Work: _____ Cell: _____

E-mail Address: _____

Emergency Contact: _____ Tel: _____ Relation: _____

How would you like to receive a reminder for your subsequent appointments? **Email / Phone**

How did you hear about our clinic? **Please circle**

Google Yelp Facebook Walk-In Website Brochure

Friend (who?) _____ Other _____

Name of Medical Doctor: _____ Tel: _____

Address: _____

Date of last appointment: _____ Date of last physical: _____

Are you taking any medications? _____ If so, what? _____

Permission to consult with the above Health Care Providers: **Yes / No**

I (please print name), _____ give permission to the discussion of any of the Information in this form amongst the team at **Tymothy Roy Wellness**.

Signature: _____ Date: _____

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MASSAGE HEALTH HISTORY

For your information: An accurate health history is important to ensure that it is safe for you to receive massage therapy treatment. If your health status changes in the future, please let me know. All information gathered is confidential except as required or allowed by law or except to facilitate diagnosis (assessment) or treatment. You will be asked to provide written authorization for release of any information.

Name: _____Today's Date: _____

Signature: _____ Date of Birth: _____

What is your primary complaint: _____

RESPIRATORY
- ☐ Chronic cough
- ☐ Shortness of Breath
- ☐ Bronchitis
- ☐ Asthma
- ☐ Emphysema

CARDIOVASCULAR
- ☐ High or Low Blood pressure
- ☐ Heart attack
- ☐ Phlebitis
- ☐ Stroke/CVA
- ☐ Pacemaker or similar device
- ☐ Heart disease
- ☐ Easy Bruising
- ☐ Varicose Veins
- ☐ Blood Clots or Clotting Disorder

INFECTIONS
- ☐ Hepatitis
- ☐ TB
- ☐ HIV / AIDS
- ☐ Skin
- ☐ Plantars Warts
- ☐ Other _____

SOFT TISSUE/JOINT DISCOMFORT AND ITS NATURE
- ☐ Neck
- ☐ Low Back
- ☐ Mid back
- ☐ Upper back
- ☐ Shoulders
- ☐ Elbows
- ☐ Wrists / Hands
- ☐ Arms
- ☐ Hips
- ☐ Knees
- ☐ Ankles / Feet
- ☐ Legs
- ☐ Muscle Cramping
- ☐ Jaw
- ☐ Weakness or Paralysis (where_____)
- ☐ Other _____

HEAD /NECK
- ☐ Vision problems
- ☐ Ear problems (eg. fullness, ringing, loss)
- ☐ Head Trauma
- ☐ Headaches / Migraines
- ☐ Sinus Problems
- ☐ Past Whiplash Injury

WOMEN
- ☐ Pregnant (due):
- ☐ Menstrual Backache
- ☐ Painful Periods
- ☐ Birth Control Method:

_____

OTHER CONDITIONS
- ☐ Loss of sensation
- ☐ Numbness / Tingling
- ☐ Dizziness
- ☐ Fainting
- ☐ Diabetes (onset):
- ☐ Allergies
- ☐ Epilepsy
- ☐ Cancer
- ☐ Arthritis (osteo or rheumatoid)
- ☐ Spinal Conditions
- ☐ Skin condition
- ☐ Chronic Fatigue
- ☐ Weight loss or gain
- ☐ Disc Herniation
- ☐ Osteoporosis
- ☐ Scoliosis
- ☐ Bone Disease

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MASSAGE HEALTH HISTORY CONT.

Current Medications: _____

_____

Condition it treats: _____

_____

Recent Special Testing (blood work, x-rays, MRI): _____

Injuries / Fractures: _____

Surgeries: _____

Do you smoke? No / Yes (how much _____)

Do you exercise? No / Yes (how often _____ Type _____)

Present involvement in other health care: No / Yes

If yes, what other therapy are you receiving _____

_____

Other Medical Conditions (i.e. digestive conditions, gynecological conditions, hemophilia, emotional or mental illness etc.)

_____

_____

Of Special Note: (presence of internal pins, wires, artificial joints, special equipment): _____

_____

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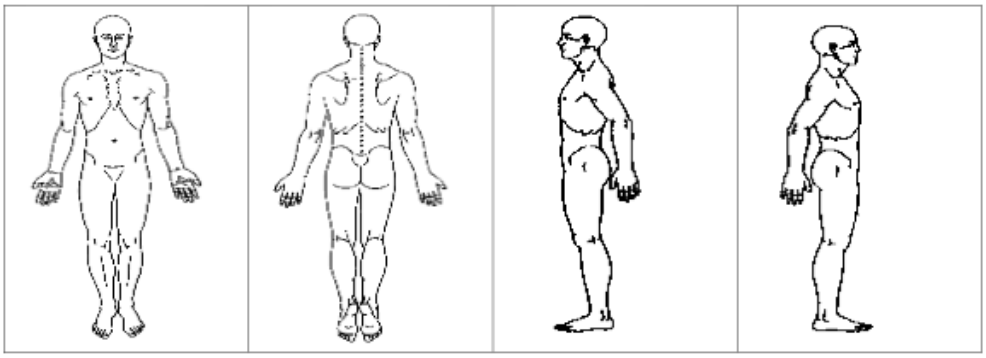
MAIN COMPLAINT

Location of the pain.



Please circle on the diagrams. Try to be as specific as you can.

Cause of the pain: _____

How long have you had the pain? _____

How frequent is the pain? (all day/night/only when you get up?) _____

How intense is the pain? (scale of 1–10) _____

How would you describe the pain? (achy, throbbing, burning) _____

What makes the pain increase? _____

What makes the pain decrease? _____

What medications are you presently taking for the condition (muscle relaxants, painkillers?)?

_____

Is there a history of this condition? _____

Have you received any other treatment for this condition? If yes, please describe and comment on its success.

_____

What results do you desire from your treatment? _____

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CANCELLATION & NO SHOW POLICY

Out of respect for your therapist and your fellow patients, we require 48 hoursadvance notice of cancellation. If you cancel your appointment with less than 48 hours notice you will be charged the full visit fee. If you do not attend a scheduled appointment and do not call to cancel or reschedule ("no show"), you will be charged the full visit charge.

I understand the cancellation and no show policy _____ (initials)

I have read, understood and am in agreement with all of the above information.

Signature: _____ Date: _____

INFORMED CONSENT TO TREATMENT

Massage Therapy involves the manipulation of the soft tissues of the body, skin, muscle, ligaments and connective tissues, using techniques to produce therapeutic results. With Massage Therapy, the client disrobes to their comfort level, and lies on a table between two sheets. Only the areas of the body being directly treated are uncovered at one time. If at any time you are uncomfortable with the pressure or technique being used, you can tell the therapist (i.e. to decrease or increase pressure, irritating, etc). You can also stop the treatment at any time. I have read the above and give consent for treatment.

Signature: _____ Date: _____