Hunterhorn Centre of Therapeutic Massage
6638 4th NE Calgary, AB T2K 6H1
Phone: 403-731-0033 Fax: 403-731-0053
www.hunterhornmassage.com

Massage Therapy/Acupuncture Health History

Date: ______________________

For your Information:
An accurate health history is important to ensure that it is safe for you to receive a Massage or Acupuncture treatment. If your health status changes in the future, please inform your therapist. All information gathered for treatment is confidential except as required or allowed by law, or except to facilitate in assessment or treatment. In any event required, you will be asked to provide written authorization for release of information

Name: ____ Date of Birth: ______________________________

Address: ____

City: ____ Postal Code: ____________________________

Home Phone: ____________________ Work Phone: ____________________ Cell Phone: ______________________

Email Address: ____
(required for online booking/appointment reminders, maybe a newsletter mail-out, never sold to third party)

Occupation: _________________________________ Employer: ____

Marital Status: ☐ Single ☐ Married Number of Children: _________________

Name of Spouse/Significant Other: ____

Family Physician Name and Address: ____

Family Physician Phone Number: _______________________

Check other Therapies you receive: ☐ Chiropractic ☐ Naturopath ☐ Physiotherapy ☐ Psychotherapy
☐ Active Release ☐ Acupuncture ☐ Other: ____________________

Date and type of last Therapy treatment: ____

How did you hear of our clinic?
☐ Sign ☐ Yellow Pages ☐ Advertising: _____________________ ☐ www.hunterhornmassage.com
☐ Other Website: ________________________________

OR

May we thank a current client for referring you? ____

Hunterhorn Centre of Therapeutic Massage
6638 4th NE Calgary, AB T2K 6H1
Phone: 403-731-0033 Fax: 403-731-0053
www.hunterhornmassage.com

Massage Therapy/Acupuncture Health History

Name: ________________________________

Check the conditions that apply to you, past and present. Please add your comments to clarify the condition.

MUSCULO-SKELETAL	SKIN	REPRODUCTIVE SYSTEM
☐ Headaches	☐ Rashes	☐ Pregnancy
☐ Joint stiffness/swelling	☐ Allergies	☐ Current
☐ Spasm/cramps	☐ Athlete's Foot	☐ Previous
☐ Broken/fractured bones	☐ Warts	☐ PMS
☐ Strains/sprains	☐ Moles	☐ Menopause
☐ Back, hip pain	☐ Acne	☐ Pelvic Inflammatory Disease
☐ Shoulder, neck, arm, hand pain	☐ Cosmetic surgery	☐ Endometriosis
☐ Leg, foot pain	☐ Breast surgery	☐ Hysterectomy
☐ Chest, ribs, abdominal pain	☐ Sensitive skin	☐ Fertility concerns
☐ Problems walking	☐ Other: ____________	☐ Prostate problems
☐ Jaw pain/TMJ	**DIGESTIVE**	**OTHER**
☐ Tendonitis	☐ Nervous stomach	☐ Loss of appetite
☐ Bursitis	☐ Indigestion	☐ Forgetfulness
☐ Arthritis	☐ Constipation	☐ Confusion
☐ Osteoporosis	☐ Intestinal gas/bloating	☐ Depression
☐ Scoliosis	☐ Diarrhea	☐ Anxiety
☐ Bone/Joint Disease	☐ Diverticulitis	☐ Difficulty concentrating
☐ Other: ____________	☐ Irritable Bowel Syndrome	☐ Hearing impaired
CIRCULATORY/RESPIRATORY	☐ Crohns Disease	☐ Visually impaired
☐ Dizziness	☐ Colitis	☐ Burning upon urination
☐ Shortness of breath	☐ Adaptive aids	☐ Bladder infection
☐ Fainting	☐ Other: ____________	☐ Eating disorder
☐ Cold feet and hands	**NERVOUS SYSTEM**	☐ Diabetes
☐ Cold sweats	☐ Numbness/tingling	☐ Hernia
☐ Swollen ankles	☐ Twitching of face	☐ Fibromyalgia
☐ Pressure sores	☐ Fatigue	☐ Post/Polio Syndrome
☐ Varicose veins	☐ Chronic pain	☐ Cancer
☐ Blood clots	☐ Sleep disorders	☐ Hemophilia
☐ Stroke	☐ Ulcers	☐ Thyroid
☐ Aneurism	☐ Paralysis	☐ Infections Disease (please list)
☐ Heart condition	☐ Herpes/Shingles	____________________
☐ Allergies	☐ Cerebral Palsy	____________________
☐ Sinus problems	☐ Epilepsy	☐ Other congenital or acquired disabilities (please list)
☐ Asthma	☐ Chronic Fatigue Syndrome	____________
☐ High blood pressure	☐ Multiple Sclerosis	____________________
☐ Low blood pressure	☐ Parkinson's Disease	Pins/wires/artificial joints (please specify)
☐ Lymphedema	☐ Spinal Cord Injury	____________________
☐ Other: ____________	☐ Other: ____________	____________________

MEDICATIONS **Reason for Medication**

____

____

____

SURGERIES **Date of the surgery**

____

____

ALLERGIES

____

I have stated all conditions that I am aware of and this information is true and accurate. I will inform the health care provider of any change in my status.

Clients Signature: ______________________________ Date: ____________________

Hunterhorn Centre of Therapeutic Massage
6638 4th NE Calgary, AB T2K 6H1
Phone: 403-731-0033 Fax: 403-731-0053
www.hunterhornmassage.com

Massage Therapy/Acupuncture Health History

Name: ______________________________

Current Problem: ____

Have you seen a doctor for this problem? If so, what was the diagnosis? ____

Describe all activities you do. ____

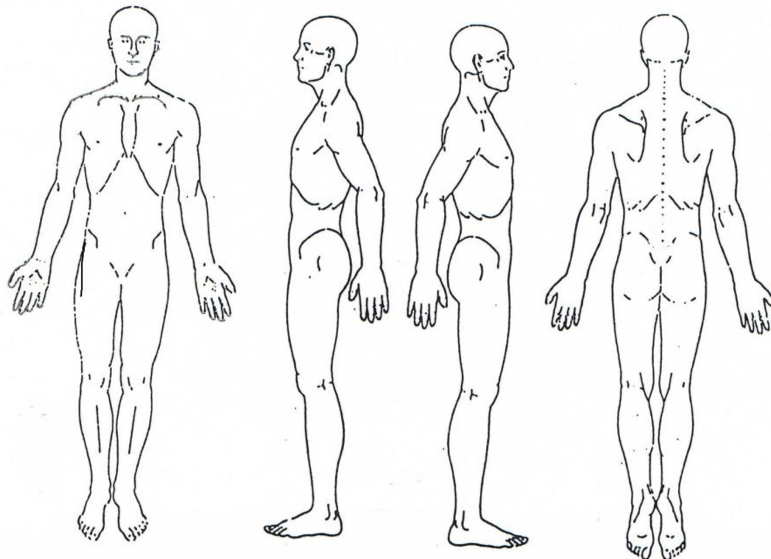
Does this condition interfere with work? ☐ Yes ☐ No   Sleep? ☐ Yes ☐ No   Daily Routine? ☐ Yes ☐ No

Please explain? ____

Please identify current problem areas of your body by drawing the appropriate symbols on the diagram below.

KEY

- O Circle where **pain** exists
- ⊗ Circle with X where **extreme pain** exists
- X Put an "X" over **stiff** areas
- >> Draw arrows over areas of **numbness and tingling**
- ≠ Mark **scars, bruises or wounds**



HOW MUCH PAIN HAVE YOU HAD BECAUSE OF YOUR CONDITION IN THE LAST WEEK?
NO PAIN ❶ ______________________ ❺ _______________________ ❿ PAIN AS BAD AS IT COULD BE

PLEASE CHECK THE TYPE OF CARE YOU DESIRE
☐ Relief Care ☐ Corrective Care ☐ Preventive Care ☐ Stress Relief Care

DO YOU EXPERIENCE PAIN DURING ANY OF THE FOLLOWING
☐ Standing ☐Driving ☐ Walking ☐ Lifting ☐Sitting

PLEASE LIST ANY AREAS YOU DO NOT WANT TREATED: ____

Hunterhorn Centre of Therapeutic Massage
6638 4th NE Calgary, AB T2K 6H1
Phone: 403-731-0033 Fax: 403-731-0053
www.hunterhornmassage.com

INFORMED CONSENT

All information provided will be held in the strictest confidence unless I issue a written request along with a signed release form allowing my practitioners to release my information to a) my lawyer, b) my insurance company c) any other health care professional that I mention.

I understand that my health questioner form may be used by any or all of the practitioners working at Hunterhorn Centre of Therapeutic Massage, but will not be used by any practitioner that leaves the above mentioned premise to work at another location. All files and records will be kept with Hunterhorn Centre of Therapeutic Massage.

I, ___________________________________ understand that massage therapy, acupuncture, reflexology and other related treatments provided at the Hunterhorn Centre of Therapeutic Massage clinic, are intended to enhance relaxation, reduce pain caused by muscle tension or spasm, increase range of motion, improve circulation, improve my active daily living and offer a positive experience of touch.

I understand that massage therapy, reflexology, acupuncture and any treatment provided at the Hunterhorn Centre of Therapeutic Massage in not a substitute for medical treatment or medication, and that it is recommended that I concurrently work with my Primary Caregiver for any condition I may have. I am aware that the massage therapist, reflexologist and acupuncturist's do not diagnose illness or disease, do not prescribe medications, and do not use spinal manipulations as part of the therapy.

I understand that Hunterhorn Centre of Therapeutic Massage is not liable for any treatments provided by the practitioners working in the above mentioned facility.

I have informed the massage therapist, acupuncturist, reflexologist of all my known physical conditions, medical conditions and medications, and I will keep the practitioners updated on any changes. I understand that there shall be no liability on the practitioner's part due to my forgetting to relay any pertinent information.

If I experience any pain or discomfort during the session, I will immediately communicate that to the therapist so the treatment can be adjusted.

I understand that I will be charged the full fee of any scheduled appointment where I do not provide 24 hours cancellation notice or fail to appear.

Client Name: __________________________________ Date: ________________________

Client Signature: _______________________________