Altitude spa

CONFIDENTIAL GUEST INFORMATION

PERSONAL DATA

Name: _____ Age: _____ D.O.B. _____

Address: _____ City, Province: _____

Postal Code:_____ Cell Number: _____Home:_____

Email: _____ Occupation: _____

Physician: _____ Chiropractor: _____

Who may we thank for referring you today? _____

Have you ever received a massage before?_____ When?_____

CLINICAL DATA

What is the purpose of your visit today?_____

Have you ever received a massage for a current problem or injury?_____

When did it start? _____

What activity/trauma caused this injury/problem? _____

What daily activities cause pain? _____

What relieves pain? _____

Does the pain radiate, if so where? _____

Any past injuries, when? _____

Have you ever been in a motor vehicle accident? If so when? _____

Do you currently have an insurance claim for this accident? _____

PRENATAL INFORMATION (if applicable)

How many weeks are you: _____

Is there anything medically I should be aware about: _____

HEALTH HISTORY (have you ever had or experienced any of these?)

☐ Arthritis	☐ Epilepsy	☐ Digestive Problems	☐ Faintness/Dizziness
☐ Muscle/Joint Stiffness	☐ Stroke	☐ Heavy feeling in limbs	☐ TMJ dysfunction
☐ Numbness/Tingling	☐ Fatigue	☐ Tightness of jaw	☐ Fibromyalgia
☐ Varicose/Spider veins	☐ Seizures	☐ Tendonitis	☐ Chronic fatigue
☐ Blood clots	☐ Heart Attack	☐ Insomnia	☐ Headaches/Migraines
☐ Bone injuries	☐ Pains in chest	☐ Hearing Problems	☐ Sciatica
☐ Cancer/tumors	☐ Constipation	☐ Diabetes	☐ Fracture

MEDICATIONS / VITAMINS / SUPPLEMENTS / HERBS

Name Reason for Taking

_____ _____

_____ _____

_____ _____

Please list any past surgeries and their date they occurred.

_____

_____

Please list any allergies that you may have.

_____

_____

Please describe the areas that are painful, experience numbness, where tight muscles are present and where you may be ticklish. For the areas where there is pain present, please rate the pain on a scale of 1 – 10, 1 being no pain at all and 10 being unbearable.

_____

_____

Please read over the following carefully:

I hereby understand the risk factors of receiving this massage and will provide full and accurate information to the therapist of any medical history that may affect my massage or cause complications during the massage. I understand that the information I am presenting to the therapist is confidential and is protected by Alberta's Freedom of Information and Protection of Privacy Act and can be reviewed upon request.

I understand that my massage therapist cannot give me any diagnosis and is NOT a doctor, if I have anything that needs medical attention or anything of concern I should consult with a physician before seeing my massage therapist.

I understand that inappropriate behaviour on my part, at the therapists' discretion, may result in termination of the massage. Further to this, I will be expected to pay the full fee of the massage and may be banned from future treatments at Altitude Laser Spa.

Client Signature: _____ Date: _____

*Parent signature is required if client is under 18 years of age Therapist Initials:_____