2 Marsellus Dr. #15
Barrie, ON
L4N 0Y4

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Massage Therapy Rates of Service:
30 minute massage: $65 45 minute massage: $85
60 minute massage: $100 90 minute massage: $135 **Date:**____________________

Name: __________________________________Age: ________________________
Address: ________________________________Home Phone#: (__) ____________
Cell Phone #: (__) ________________________Date of Birth: _________________
City: ______________________Province: ____________Postal Code: ____________
E-Mail Address: ___________________________
May we have your permission to contact you via email?: (circle one) YES NO
Occupation: __________________________
Employer: ___________________________Work Phone #: (__) _______________
How did you hear about our clinic? ____

Health History: Please indicate conditions you are experiencing, or have experienced:

Respiratory:
__chronic cough
__shortness of breath
__bronchitis
__asthma
__emphysema
__family history of the above?

Cardiovascular:
__high blood pressure
__low blood pressure
__CHF
__heart attack
__phlebitis
__stroke/ CVA
__pacemaker or similar device
__heart disease

Skin:
__ skin conditions/sensitivities
__List:___________________

Women
__Pregnant? Due Date_______________________

Other Conditions:
__loss of sensation
__diabetes? Type & onset:______________________
__arthritis
__family history of arthritis
__epilepsy
__cancer
__allergies? List:____________
__fibromyalgia

Head/ Sensory:
__vision problems
__vision loss
__ear problems
__hearing loss
__headaches or __ migraine

Infections:
__hepatitis
__skin
__TB
__HIV
__Other:__________________

Soft tissue/ joint discomfort & its nature (ie: ache/ pains/ sprain):
__head/neck______________________
__shoulders/arms_________________
__upper back ____________________
__middle back ___________________
__low back _____________________
__hips/legs _____________________
__knee s________________________
__feet/ ankle ____________________
__other _________________________
__car accidents?
when? _______________________

Other Medical Conditions (eg: digestive concerns, gynecological conditions, hemophilia, etc.)________________
____

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

Are you receiving any other treatment? (ie: chiropractic, naturopath?) ___yes, ___no, Please specify____________________

How is your overall health? ____
Current Medication(s) ___________________Condition it treats____________________
Surgeries_______________________________Injuries____________________________
Family Physician________________________ Phone #:___________________________
May we contact your Physician with regard to your massage treatment? YES NO

<u>**PAIN ASSESSMENT**</u>

Patient Name______________________________ Date______________________

Using the diagrams below, please indicate the areas in which you are experiencing symptoms. Please indicate the type of pain/ discomfort using the appropriate symbols, and including all affected areas.

Dull Aching: XXX XXX	Sharp Pain /////// ///////	Burning \\\\\\\\\ \\\\\\\\\
Numbness +++ +++	Pins & Needles **ooo** **ooo**