Top Thai Massage Therapy

Name:_____ Address:_____

City:_____ Province:_____ Postal Code:_____

Home No. :_____ Work No. :_____ Cell No. :_____

Date of Birth:_____ Male or Female

Occupation:_____

E-Mail:_____

Emergency Contact Person:_____ Phone:_____

Have you ever had a massage before? Yes ☐ No ☐

Where did you hear about the clinic:_____ Name of Referral:_____

What is your current concern in detail:_____

Medical History

Are you under the care of a:

		Name:
Chiropractor	☐	_____
Physiotherapist	☐	_____
Physician	☐	_____

Do you suffer from:

High Blood Pressure	☐	Epilepsy	☐	
Low Blood Pressure	☐	Diabetes	☐	
Arteriosclerosis	☐	Cancer	☐	Type:_____
Circulatory Problems	☐	Skin Disorder	☐	
Heart Conditions	☐	Respiratory Disorder	☐	
Arthritis	☐	Other: _____		

Do you experience headaches and/or migraines? Yes ☐ No ☐

If yes, please describe: _____

Do you have untreated osteoporosis Y or N

Do you have deep vein thrombosis Y or N

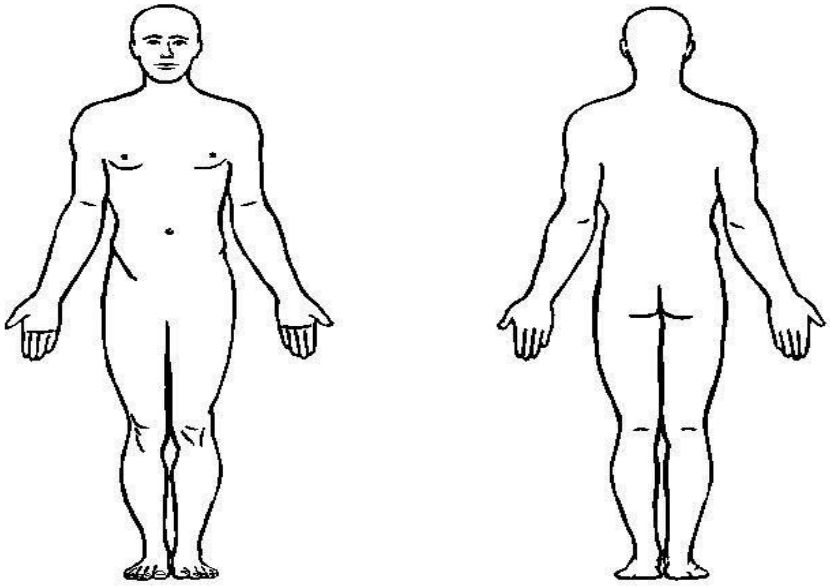
Do you have varicose veins Y or N

Do you sleep well? Yes ☐ No ☐

If no, please describe: _____

Please indicate the following on diagram below:

- Area(s) of pain
- Previous Surgeries (year)
- Motor Vehicle Accident(s) Date(s): _____



Are there any other physical or emotional conditions you feel I should be aware of:

_____

If Female:

Menopause Yes ☐ No ☐

Are you pregnant Yes ☐ No ☐ Weeks: _____

I, _____ have stated all medical conditions that I am aware of and will update my massage therapist of any of any changes in my health status as they occur.

<u>CANCELLATION NOTICE</u>: 24 Hour notice is required to cancel any massage appointment. I understand there will be a $30 charge +GST ($45 for 90 min) should there be any cancellation after the 24 hour notice.

Signature: _____ Date: _____