Benmiller Inn & Spa

Massage and Holistic Services Health History Form

The information request below will assist us in treating you safely. Feel free to ask any questions about the information being requested. Please note that all information provided below will be kept confidentially unless your written permission allows it or we are required by law. **Please be aware that some of our products may contain traces of nuts!**

Name: _____ Phone # (_____)_____

Address: _____

Occupation: _____ Date of Birth: _____

Have you received massage therapy before? ☐ Yes ☐ No

Did a health care practitioner refer you for massage therapy? ☐ Yes ☐ No

If yes, please provide their name and address _____

Please indicate conditions you are experiencing or have experienced:

Cardiovascular

- ☐ High blood pressure
- ☐ Low blood pressure
- ☐ Chronic congestive heart failure
- ☐ Heart attack
- ☐ Phlebitis / varicose veins
- ☐ Stroke / CVA
- ☐ Pacemaker or similar device
- ☐ Heart disease

Is there a family history of any of the above? Yes☐ No ☐

Respiratory

- ☐ Chronic cough
- ☐ Shortness of breath
- ☐ Bronchitis
- ☐ Asthma
- ☐ Emphysema

Is there a family history of any of the above? ☐ Yes ☐ No

Infections

- ☐ Hepatitis
- ☐ Skin conditions
- ☐ TB
- ☐ HIV
- ☐ Herpes

Other Conditions

- ☐ Loss of sensation. Where? _____
- ☐ Diabetes, onset: _____
- ☐ Allergies. Hypersensitivity to what? _____

Type of reaction _____

- ☐ Epilepsy
- ☐ Cancer, where? _____
- ☐ Skin conditions, what? _____
- ☐ Arthritis

Is there a family history of any of the above? ☐ Yes ☐ No

Head/Neck

- ☐ History of headaches
- ☐ History of migraines
- ☐ Vision problems
- ☐ Vision loss
- ☐ Ear problems
- ☐ Hearing loss

Women

Pregnant, due: _____

Gynaecological conditions, what? _____

Overall

How is your general health? _____

Primary Care Physician: _____

Physician Address: _____

_____

Current Medications: _____

_____

Condition it treats: _____

Are you currently receiving treatment from another heath care professional? ☐ Yes ☐ No

If yes, for what? _____

Surgery – date _____

Nature: _____

Injury – date _____

Nature: _____

Do you have any other medical conditions? (e.g. digestive conditions, haemophilia, osteoporosis, mental illness)

☐ Yes ☐ No What? _____

Do you have any internal pins, wires, artificial joints or special equipment? ☐ Yes ☐ No

What? _____

Where? _____

What is the reason you are seeking massage therapy? Please include the location of any tissue or joint discomfort._____

_____

By signing this form, I fully understand and agree to everything on this client form.

Guest Signature: _____

ONGOING MASSAGE THERAPY CLINICAL NOTES

Verbal Informed Consent Received: _____
Patient: _____ Therapist: _____ RMT
File #: _____ Date: _____ Time: _____ am/pm. Duration: _____ min. Fee: $_____
Assessment: _____
_____
_____
_____

Area Treated: Back __ Neck__ Shoulders__ Face__ Gluteals__
VC__ Arms L/R Legs L/R Chest__ Abdominals__ Breast__
Other: _____

Techniques Used: Stroking __ Rocking __ Effleurage __ Petrissage __ Friction __ Vibration __
Tapotment __ Fascial __ Intra-Oral __ Stretch __ Breast Massage __ Written Consent __
TrP: isch comp __, Muscle Stripping __, Other: _____
High Grade Joint Mobilization _____ Low Grade Joint Mobilization_____
STR __ Other:_____
Hydrotherapy: _____ Pre / During / Post
Notes:_____
_____
_____
_____
Stretch: _____
_____
_____
Hydrotherapy: _____
_____
_____
Plan: _____
_____

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