



South Calgary Acupuncture Centre

Massage
Medical History Form

Name _____ Birth Date _____

Address _____

City _____ Province _____ Postal Code _____

Phone Number (____) _____ Work (____) _____

Have you ever received massage therapy? _____

Current Complaints: _____

Please check off any you have ever experienced or currently are experiencing:

_high blood pressure

_cancer

_sprains

_low blood pressure

_arthritis

_strains

_poor circulation

_diabetes

_constipation

_varicose veins

_migraines

_seizures

_inflammation

_headaches

_whiplash

_heart problems

_stress

_stroke

_blood clotting disorders

_sciatica

_skin conditions

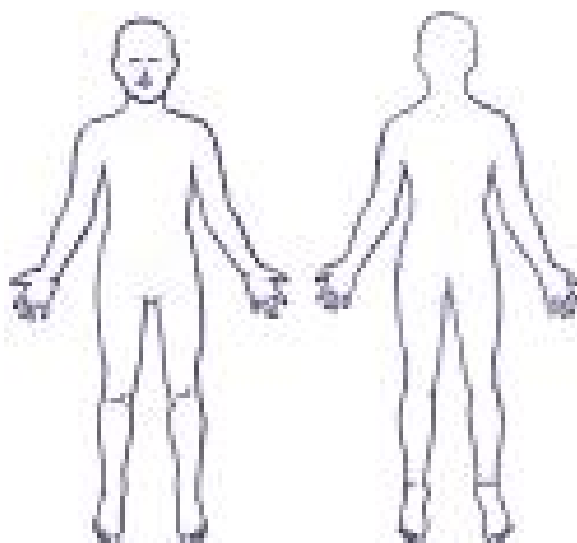
_allergies _____

_bursitis

_pregnancy

Other conditions: _____

Please indicate the area(s) where you are experiencing pain or discomfort:





How long have you been experiencing this discomfort? _____

Please indicate the level of intensity of your discomfort:

1—2—3—4—5—6—7—8—9—10

Any extra information you would like me to know: _____

Please read the following closely, then sign and date.

I understand the massages given are for a therapeutic purpose to relive stress and tension in soft tissue injuries.

I understand that the massage therapist cannot diagnose or prescribe medical treatment. That it is recommended I see a medical doctor for any physical ailment and keep the massage therapist aware of my on going physical health.

I have stated all known medical conditions and pre-existing conditions, and will update as necessary.

Signature: _____ Date: _____