20/20 MASSAGE & WELLNESS INC.

BENEFIT THROUGH MASSAGE

PLEASE FILL OUT THIS FORM BEFORE YOUR APPOINTMENT

FULL NAME: ____ GENDER: ____________

DATE OF BIRTH: ___________ OCCUPATION: _______________ EMAIL: _________________________

STREET ADDRESS: ____POSTAL CODE: _____________

HOME PH#: ______________ CELL #: ___________________WORK #:________________

WOULD YOU BE INTERESTED TO BE ON OUR MAILING LIST FOR SPECIAL OFFERS? Yes / No

HOW DID YOU HEAR ABOUT 20/20 MASSAGE & WELLNESS INC? _________________________________

EMERGENCY CONTACT NAME & NR: ____

NAME OF FAMILY DOCTOR: ____

PHONE # OF DOCTOR: ____________________

WERE YOU REFERRED BY A DOCTOR? Yes / No

DO YOU HAVE MEDICAL INSURANCE? Yes / No

INSURANCE COMPANY	PLAN # / ID #

ARE YOU CURRENTLY SEEING ANY OTHER HEALTHCARE PRACTIOTIONERS? (SELECT IF APPLICABLE)

- ☐ Acupuncturist
- ☐ Osteopath
- ☐ Chiropractor
- ☐ Physiotherapist
- ☐ Naturopath
- ☐ Other Explain: ____

LIST OF MAJOR SURGERIES:

SURGERY	DATE OF SURGERY

LIST OF ANY CURRENT MEDICATION(S):

____ ____

____ ____

20/20 MASSAGE & WELLNESS INC.

HAVE YOU HAD A MASSAGE BEFORE? Yes / No

PLEASE RATE YOUR CURRENT SENSE OF OVERALL HEALTH AND WELLBEING

- ☐ Great
- ☐ Average
- ☐ Poor

WHICH OF THE FOLLOWING PROMPTED YOUR VISIT TODAY?

- ☐ Injury/Pain
- ☐ Stress
- ☐ Other

HAVE YOU BEEN IN AN AUTOMOBILE ACCIDENT OR DO YOU HAVE ANY INJURY WE SHOULD KNOW ABOUT?

EXPLAIN: ____

ARE YOU AFFECTED BY ANY OF THE FOLLOWING CONDITIONS? (SELECT IF APPLICABLE)

- ☐ Allergies or Hypersensitivity Reactions (Specify) ____
- ☐ Asthma/Emphysema/Chronic Cough
- ☐ Arthritis/Bursitis
- ☐ Athlete's Foot
- ☐ Carpal Tunnel Syndrome
- ☐ Cancer ____
- ☐ Crohn's/ Colitis
- ☐ Depression or/other Mental illness
- ☐ Diabetes
- ☐ Edema
- ☐ Epilepsy
- ☐ Fever
- ☐ Fibromyalgia
- ☐ Flu/Cold Virus
- ☐ Gastro-Intestinal/Digestive Ailments
- ☐ Headaches/Migraines
- ☐ Hearing or Vision Loss
- ☐ Heart Attack/Failure
- ☐ Hepatitis A, B, or C or Herpes
- ☐ Cholesterol
- ☐ High/Low Blood Pressure
- ☐ HIV/AIDS
- ☐ Infectious Diseases
- ☐ Metal Plates/Screws/Implants
- ☐ Neck/Spine Injury
- ☐ Numbness/Tingling
- ☐ Osteoporosis
- ☐ Pacemaker
- ☐ Poor Circulation
- ☐ Pregnancy
- ☐ Recent surgery
- ☐ Shingles
- ☐ Skin Irritations/Rashes/Warts
- ☐ Smoker
- ☐ Sports Injury
- ☐ Stroke/Aneurysm
- ☐ Varicose Veins/ Phlebitis

ANY FAMILY HISTORY OF A SPECIFIC DONDITION?

EXPLAIN: ____

ARE YOU RECEIVING ANY ONGOING MEDICAL CARE FOR ANY CONDITIONS NOT LISTED? Yes / No

EXPLAIN: ____

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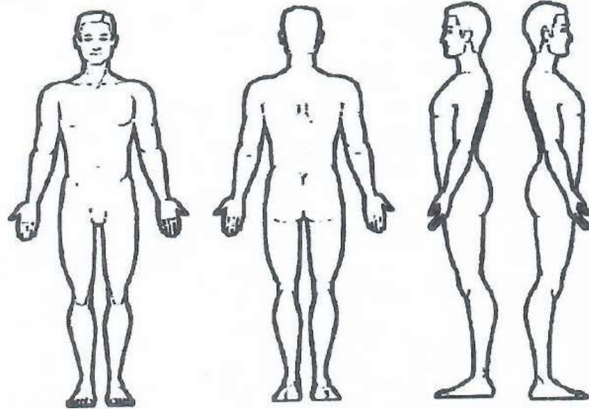
IN WHAT AREA(S) ARE YOU CURRENTLY EXPERIENCING TISSUE, JOINT, OR MUSCLE DISCOMFORT?

Circle on below picture or check the boxes that apply.

- ☐ Jaw
- ☐ Neck
- ☐ Shoulders
- ☐ Lower Back
- ☐ Middle back
- ☐ Arms
- ☐ Hands
- ☐ Hips
- ☐ Glutes
- ☐ Knees
- ☐ Legs
- ☐ Calves
- ☐ Feet



PLEASE READ AND ACKNOWLEDGE BY SIGNING THE BELOW

- ✓ To the best of your knowledge the above information is true and is the most up-to-date information you can give the attending massage therapist.
- ✓ As your health status changes, you will advise us, so that we may update your file. Failure on your part to disclose any health information could possibly result in an injury or illness, and you hereby release 20/20 Massage & Wellness Inc. from any claims resulting as such.
- ✓ If required for treatment purposes, you authorize 20/20 Massage & Wellness Inc. to contact the above doctor or health-related specialist.
- ✓ You are expected to be punctual as your treatment time has been especially reserved for you and will not be extended.
- ✓ You understand that all appointment times include a pre-health assessment, or health consultation, as well as appropriate change time.
- ✓ You understand that the information given is confidential, unless required by law, and will only be released with your written consent.
- ✓ It is by your free-will that you are receiving this massage therapy today and in future visits.
- ✓ You understand that the therapist can terminate treatment at any point due to inappropriate behaviour.
- ✓ You understand that 24 hour notice is required to cancel or reschedule all appointments.

SIGNATURE: ___________________________________ DATE: ______________