Serene Physique
Massage Therapy and Wellness Clinic
475 Millidge Avenue
Saint John, N.B.
(506) 652- 4325

Health History

I acknowledge that by seeking treatment, I will receive a professional Massage Therapy treatment at Serene Physique by a Registered Massage Therapist. The intent of the treatment is to promote the health of the client and the condition which is being treated.

I understand the information provided on this form is confidential and will not be shared outside the health care field without my written consent.

I confirm the information supplied on this form is true to the best of my knowledge and no medical information has been with held. You have my consent to treat.

Signature:______________________________ Date:___________________

Name :_____________________ Date of Birth: __________Ht:______ Wt:______
Address:____ Postal Code: _______
Telephone : (Home) _________________ (Work) _____________________ ext._____
E-Mail ____
Occupation:____
Where Did You Hear About This Clinic? _______________________________

Assessment Information

The following is critical to be accurate as possible:

Chief Complaint:____
Other Complaints:____
Type of Pain (ex. Achy, burning , throbbing etc.)____
What aggravates the pain?____
What relieves the pain?____
Have you received any other health care providers for this condition?

- Chiropractor
- Physiotherapist
- Massage Therapist
- Athletic Trainer

Medical Doctor:
Name: ______________________
Phone:__________________
Date of last Visit:__________________

Current Medications:
Name of Med(s)___________________
For what condition:____________________
____

Surgery:
Type:____________________________
Date:____________________________
Symptoms:_________________________

Injuries / Accidents:
Type:________________________________
Date: _______________________________
Current Symptoms:____________________

(Please circle the condition that you are currently experiencing, or have experienced in the past)

HEAD / NECK

* Headaches
* Vision Problems
* Contact Lenses
* Sinus
* Earaches

DIGESTIVE

* Constipation
* Ulcers
* Liver / Gall Bladder

MUSCLES / JOINTS

- ☐ Pain / Stiffness
- ☐ Limitations in movement
- ☐ Osteo Arthritis
- ☐ Rheumatoid Arthritis
- ☐ Neck Pain
- ☐ Shoulder Pain
- ☐ Back Pain
- ☐ Leg / Knee Pain : ____ Left, ____Right
- ☐ Other:____________________________

CARDIOVASCULAR

* Stroke
* High Blood Pressure
* Low Blood Pressure
* Poor Circulations
* Phlebitis
* Heart Disease
* Varicose Veins
* Dr. Diagnosed ?

INFECTIONS

* Hepatitis
* Plantar Warts
* HIV / AIDS

WOMEN

* Menstrual Problems
* Menopause
* Pregnant

SKIN

* Sensitivity
* Rashes
* Contagious Condition

URO

* Frequent Urination
* Kidney
* Bladder
* Diabetes

GOOD SLEEPING PATTERNS

* _____ YES * ______ NO

Other Healthcare / Medical Conditions?
(Ie: Nervousness , Depression): ______________________________

* **Allergies**: ____

* **SPECIAL NOTE*** Please indicate if you have any of the following;
Pins, Wires, Artificial joints, special equipment such as wheel chair,
Walker, cane, etc. ____