The Wellness Room in Studio Blue

All information provided will be kept **private** and **confidential**. Your written consent is required for the release of information in the case that it is required by law.

Please be as thorough as possible in this health history form, it will put us in the best position to create a safe and effective treatment for you will see better results and get the most out of your time.

Today's Date: _____

Last Name _____ First Name _____

Birth date ____/____/____ (dd/mm/yy)

Phone _____

Address _____

Postal code _____ City/Province _____

Primary Healthcare Provider

Name_____

Address _____

Postal code _____ City/Province _____

Are you currently seeing any other health practitioner? Yes No

_____

_____

Do you have any allergies or sensitivities?

_____

_____

Are you taking any medications?
If so what condition(s) are they for, and do you experience side effects?

_____

_____

_____

Surgery? Date?

_____

_____

_____

Injuries (fractures, sprains, strains...etc)? Date?

_____

_____

_____

Have you experienced or been diagnosed with any of the following…

- Cardiovascular issue
- Respiratory condition
- Diabetes
- Bone disease/Arthritis
- Autoimmune disorder
- Neurological condition
- Skin infections/warts
- Epilepsy
- Cancer

Do you have a family history of any of the above? Yes No

Please provide details (medical condition, date of onset...etc)

_____
_____
_____
_____
_____

I, _____ (print name), confirm that all information in this health form is accurate and complete. I acknowledge that health information needs to be updated annually or anytime there is a change in health status, in order for my massage therapy treatments to be as safe and effective as possible.

Signature _____

Updated:_____
Updated:_____
Updated:_____
Updated:_____