REALIGN
LIVING HEALTHY

Massage Therapy

Health History and Entrance Form

A complete health history helps us ensure it is safe to provide you with a massage treatment; please let us know if your status changes so we can update your form. All information given to us is confidential.

Name _____ Email _____

We collect your email address to send you appointment reminders. Your email address will never be shared with a third party.

Home Phone _____ Cell Phone _____ Work Phone _____

Street _____ Unit _____ City _____ Prov. _____ Postal Code _____

Date of Birth (MM-DD-YY) _____ Age _____ Gender _____ Occupation _____

Emergency Contact Name _____ Emergency Contact Phone _____

Doctor's Name _____ Phone _____ . _____

Were you referred by another health care practitioner? If yes, who _____

Have you had a professional massage before? ☐ Yes ☐ No If yes, approximate date of last therapeutic massage _____

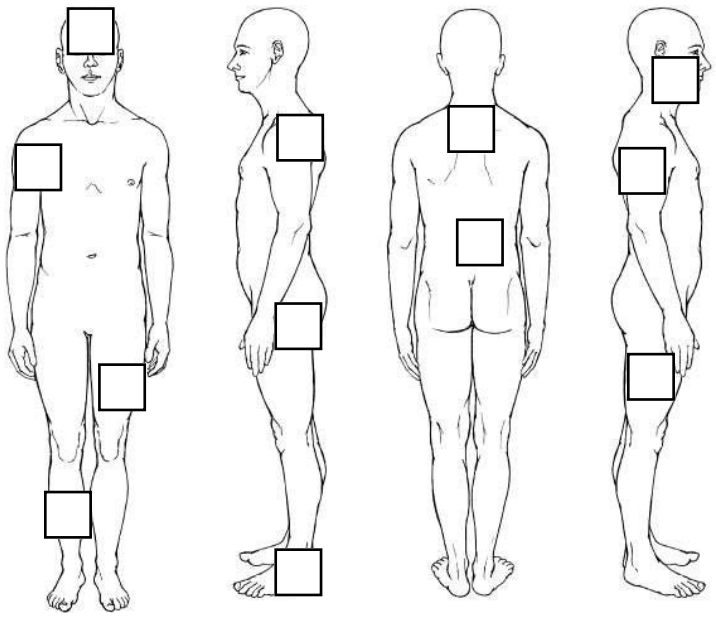
Do you see other healthcare practitioners? ☐ Chiro ☐ Physio ☐ Naturopath ☐ Osteopath ☐ Other _____

Current Medications and Conditions Treating _____

Previous Major Illnesses/Operations (include dates) _____

Major Accidents _____

Please indicate areas you would like us to focus on and your primary area of complaint.



What is your primary complaint?

_____

_____

_____

_____

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

Joint/Muscle
- ☐ Jaw
- ☐ Neck
- ☐ Shoulders
- ☐ Arms
- ☐ Hands
- ☐ Upper back
- ☐ Mid back
- ☐ Low back
- ☐ Hips
- ☐ Knees
- ☐ Feet

Lifestyle (check all that apply)

Regular exercise	☐yes	☐no	☐mostly
Drink plenty of water	☐yes	☐no	☐mostly
8 hours of sleep nightly	☐yes	☐no	☐mostly
Good eating habits	☐yes	☐no	☐mostly

What is your general health?

_____

_____

Cardiovascular
- ☐ High blood pressure
- ☐ Low blood pressure
- ☐ Heart attack/disease
- ☐ Congestive heart failure
- ☐ Stroke/aneurysm
- ☐ Pacemaker
- ☐ Varicose veins/phlebitis

Other
- ☐ Fever
- ☐ Arthritis OA/RA
- ☐ Headaches/migraines
- ☐ Loss of sensation/numbness/tingling
- ☐ Diabetes, onset _____
- ☐ Cancer, where _____
- ☐ Epilepsy
- ☐ Haemophilia
- ☐ Neuromuscular conditions
- ☐ Osteoporosis
- ☐ Mental illness
- ☐ Skin conditions
  what _____
- ☐ Artificial implants / pins / plates;
  where _____

EENT
- ☐ Vision loss/problems
- ☐ Dental problems
- ☐ Hearing loss/ear problems
- ☐ Hearing aid
- ☐ Sinus problems
- ☐ Allergies/hypersensitivity to
  type of reaction _____

Reproductive
- ☐ Pregnant, due _____

Please read and sign:

- I attest that the information I have provided is true and complete to the best of my knowledge.
- I understand the information I have provided on this form is confidential and will not be released without my written consent.
- I understand that the therapist can end treatment at anytime due to inappropriate behaviour.
- I consent to a health assessment/reassessments and therapeutic massage treatment at ReAlign Health.
- I authorize Realign Health to contact my doctor or other health care professional listed above if required for treatment purposes.
- I understand that all sessions include a pre-health assessment and change time.
- I understand 24 hours notice is required to reschedule all future appointments, or full charges will apply.

Signature _____ Today's Date _____

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ReAlign Health Massage Appointment Credit Card Authorization Form

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Patient Information
Full Name: _____
Phone Number: _____

Credit Card Information
Name on Card: _____
Credit Card Number: _____
Expiration Date (MM/YY): _____ CVC (Security Code): _____

Authorization and Agreement

- I, the undersigned, authorize ReAlign Health to securely store my credit card information and charge the above card if I fail to provide at least one (1) full business day's notice for appointment cancellations or if I do not attend my scheduled massage appointment. A no-show will be assumed if I arrive more than 15 minutes after my scheduled start time.
- I acknowledge that the charge will be for the **full cost of the missed appointment**.
- I agree that ReAlign Health will store my credit card information in a secure and encrypted format.

Terms of Agreement

- Cancellations or rescheduling must be made at least **one (1) business day** before the scheduled appointment.
- Failure to do so will result in a charge to the above credit card for the **full cost** of the missed appointment.

By signing below, I agree to the terms stated above and authorize ReAlign Health to charge my credit card under these circumstances.

Signature: _____
Date: _____

ReAlign Health is committed to ensuring the security and confidentiality of your credit card information. Your data will be encrypted and stored securely in compliance with all applicable privacy laws.