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| **Medical History** | | |
| **Name:** | | |
| **Do you have any serious illness?** | Yes    No | Describe: |
| **Have you been hospitalized Recently?** | Yes    No | Why/When: |
| **Any broken bones in your past?** | Yes    No | Where/When: |
| **Recent surgeries?** | Yes    No | Where/When: |
| **Heart issues?** | Yes    No | What/When: |
| **Pacemaker?** | Yes    No | When: |
| **Blood pressure:** | High   Low        Normal | |
| **Circulatory issues?** | Yes    No | What/When? |
| **Are you pregnant?** | Yes    No | Trimester? |
| **Any history of cancer?** | Yes    No | What/When? |
| **Smoker?** | Yes    No | How long? |
| **Headaches?** | Yes    No | How Often? |
| **Diabetes?** | Yes    No | Type/when? |
| **Epilepsy?** | Yes    No | What/when? |
| **Allergies?** | Yes    No | List? |
| **Arthritis?** | Yes    No | What/Where? |
| **Digestive issues?** | Yes    No | What/Where? |
| **Muscular issues, aches/pains?** | Yes    No | What/Where |
| **Insomnia/sleep issues?** | Yes    No | Describe? |
| **Exercise regularly?** | Yes    No | What/How often? |
| **Have you had reflexology before?** | Yes    No | Where/When? |
| **Have you had reiki before?** | Yes    No | Where/When? |
| **Have you had indie head massage before?** | Yes    No | Where/When? |
| **Reason you are coming for therapy?**(current issues/problems) |  | |
| **Are you currently receiving other therapies?** | Massage       Chiropractic        Physiotherapy      Acupuncture           Yoga                  Pilates                        Reiki                   Other        Other    \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | |
| **Consent and Disclaimer** | | |
| I understand and accept that the treatments received are for therapeutic relaxation and stress reduction only and fully accept responsibility for the same. Treatment provided is not intended to be a substitute for the professional medical advice, diagnosis or treatment provided by your own Medical Doctor or Health Care Provider. For the diagnosis of any disease, please always consult a licensed physician. **The Therapist must be aware of existing physical conditions; I have stated all my known medical conditions and take it upon myself to keep the therapist updated on my health.**  **·        I understand that the therapist can end treatment at any time due to inappropriate behaviour**  **·        I understand that all appointments include an assessment and change time**  **·        I understand 24 hours’ notice is required to cancel or reschedule an appointment or full charges will apply.**  **·        I consent to an initial assessment/reassessments and Holistic therapeutic treatments at Chill Massage Therapy and Yoga Inc.**  **I therefore release the company and the individual practitioner from all liability and understand that there may be additional risks based on my physical condition.**  Signature: | | |