SERENITY THERAPEUTICS

Confidential Health Record

Date: ______________________________

Please complete both pages.

Name: ______________________________ Gender Pronoun: ______________

Street: ______________________ City ______________ Postal Code: __________

Work #: ______________ Home #: ______________ Cell #: ______________

E-Mail: ______________________ Referred By: ______________________

DOB (m/d/y): ____________ Occupation: ____________ Company: ____________

Primary M.D.: ______________ Phone #: __________ Address: ______________

Place a checkmark in the gray areas below to the RIGHT of the conditions that you have or have had.

Cardiovascular	**Present**	**Past**	**Other Conditions:**	**Present**	**Past**	**Reproductive**	**Present**	**Past**
High blood pressure			Constipation			Painful menstruation		
Low blood pressure			Liver			Pregnant Due: ____ /____ /____		
Poor circulation			Kidney					
Heart attack			Bladder			# of children		
Heart disease			Gall Bladder			Menopausal concerns		
Phlebitis			Diabetes (onset)					
Stroke								
Vericose veins			Sinus concerns (type)			**Infections:**		
						Hepatitis		
Respiratory:			Insomnia			Tuberculosis		
Smoking			Epilepsy			HIV/AIDS		
Chronic cough			Osteoporosis			Herpes		
Shortness of breath			Cancer (type)			Planters warts		
Bronchitis						Other		
Asthma			Arthritis (type)					
Emphysema						**Stiffness/Pain:**		
Other breathing Concerns/allergies (type)						Neck		
			Head/Neck:			Upper back		
			Headaches			Mid back		
			Vision concerns			Lower back		
Skin:			Vision loss			Shoulders (L/R)		
Skin conditions/allergies/			Contact Lenses			Legs (L/R)		
Loss of sensation			Ear concerns (type)			Knees (L/R)		
						Other		
			Hearing loss					

Summary of regular exercise: ____

____ Frequency? ______________

Other Health Care Activities? Please check the following if you are currently receiving:

☐ Chiropractic ☐ Physiotherapy ☐ Acupuncture ☐ Naturopathy ☐ Homeopathy ☐ Yoga ☐ Pilates ☐ Shiatsu ☐ Rolfing
☐ Craniosacral ☐ Massage Therapy ☐ Thai Massage ☐ Osteopathy ☐ Colonics ☐ Tai Chi ☐ Reflexology ☐ Psychotherapy

Other: ____

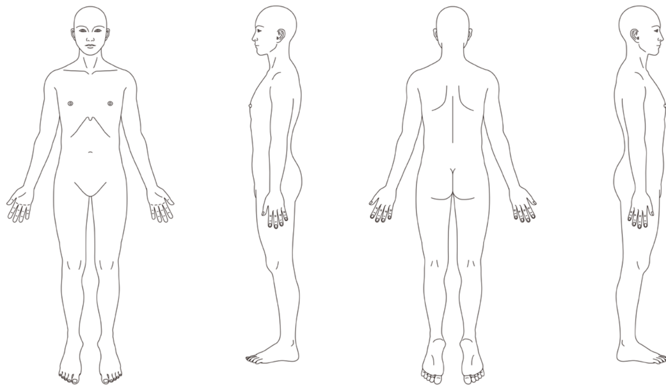
Please check the following if you have received in the past:

☐ Chiropractic ☐ Physiotherapy ☐ Acupuncture ☐ Naturopathy ☐ Homeopathy ☐ Yoga ☐ Pilates ☐ Shiatsu ☐ Rolfing
☐ Craniosacral ☐ Massage Therapy ☐ Thai Massage ☐ Osteopathy ☐ Colonics ☐ Tai Chi ☐ Reflexology ☐ Psychotherapy

Other: ____

Medication Name	Prescribed For:	Surgery/Injury	Date:
1.		1.	
2.		2.	
3.		3.	
4.		4.	
5.		5.	
6.		Other medical considerations:	
7.			
8.			
9.		Internal pins, wires, artificial joints, etc.	
10.			
11.			

Please circle or mark on the diagram below where you feel pain or discomfort?



Please check the number that best represents the amount of pain you are currently experiencing:

No pain/Full function ☐0 ☐1 ☐2 ☐3 ☐4 ☐5 ☐6 ☐7 ☐8 ☐9 ☐10 Extreme pain/No function

CONSENT TO TREATMENT

I understand that massage therapy involves manipulating the soft tissues and joints of the body in order to develop, maintain, rehabilitate or improve physical function and relieve pain. During the massage treatment I will remain respectfully draped (Swedish & Hot Stone) or clothed (Thai Massage), with comfort, security and privacy in mind.

I understand that during the course of the treatment, the massage therapist will be open to any questions about procedure or effects. I understand the whole external body, excluding private areas, may be massaged.

I further understand that at any time before or during treatment, the therapist will respect my communication that I not be massaged in any particular area of the body, or that I wish to stop or modify treatment for any reason.

All information exchanged between myself and the therapist is confidential and requires my consent for release unless the therapist is legally obligated to disclose information.

I understand that my accurate and up to date health history is imperative to ensuring a safe and effective treatment, and that I must notify the massage therapist as soon as any information changes.

I hereby consent to massage therapy as discussed between myself and the therapist, and agree that the given health history information is complete and accurate.

A MISSED APPOINTMENT WITHOUT AT LEAST 24 HOURS NOTICE OF CANCELLATION WILL BE BILLED TO MY ACCOUNT. IF I ARRIVE LATE FOR AN APPOINTMENT, I WILL PAY THE FULL SESSION FEE, AND THE APPOINTMENT WILL END AT THE SCHEDULED TIME.

Date ____________________ Signature ____

My health information remains unchanged: Date:__________ Initials:________ ; Date:__________ Initials:________

Date:__________ Initials:________ ; Date:__________ Initials:________ ; Date:__________ Initials:________