Advantage Massage Therapy | Putting Your Health First

Name: _____ Date of Birth: _____
Address: _____ City: _____
Province: _____ Postal Code: _____
Family Doctor: _____
Phone: (H) _____ (C) _____ (W) Email Address: _____
Occupation: _____

Do you have insurance coverage for massage therapy? _____
Insurance company: _____
Reason for your visit today: _____

Please circle the following "problem areas" that apply to you:

☐ Neck	☐ Upper back	☐ Lower Back	☐ Mid Back	☐ Shoulder
☐ Elbow	☐ Arm	☐ Wrist	☐ Hand	☐ Hip
☐ Leg	☐ Headaches	☐ Foot	☐ TM (Jaw)	☐ Other

Medications and reason for use: _____
Past Surgeries or Injuries: _____
Allergies: _____

Please check any of the following that apply to you:

☐ Pregnant	☐ Numbness/Tingling	☐ Trouble breathing/asthma	☐ Chest pain
☐ Dizziness	☐ Abdominal pain	☐ Prolonged constipation	☐ Hepatitis
☐ Diabetes	☐ Cancer	☐ Blood pressure	☐ HIV/Aids
☐ Stroke	☐ Heart Attack	☐ Haemophilia	☐ Epilepsy
☐ Parkinson's	☐ Multiple Sclerosis	☐ Hearing loss	☐ Vision loss
☐ Tuberculosis	☐ Osteoporosis	☐ Arthritis	☐ COPD
☐ Migraines			

Any other conditions or symptoms not listed above: _____

How did you hear about Advantage Massage Therapy? _____

CONSENT FOR TREATMENT :

I hereby give my consent for the assessment and treatment of the above-named person by Advantage Massage Therapy. I authorize the release of medical information/reports/ results to Advantage Massage Therapy. I also authorize the release of medical information to my private/ section B insurance company as may be necessary to process any insurance claim or coverage.

Signature _____
Date _____

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www.advantagenb.com