Kathy Donaldson RMT

Windsor Medical Aesthetics 136 Allan Street, Oakville

Please fill out the following thoroughly and honestly so that the massage can be tailored specifically to meet your needs. All client information is confidential and written authorization will be attained prior to release of information. Please inform the Massage Therapist of any change in health as it happens.

Name _____

Phone_____ Email _____

Address_____City _____Postal Code _____

Problems Past or Present

- ☐ Allergies Type_____
- ☐ Aneurysm
- ☐ Arthritis
- ☐ Asthma
- ☐ Bone Fractures
- ☐ Bronchitis
- ☐ Buerger's Disease
- ☐ Cancer: When_____ Type_____
- ☐ Chronic Congestive Heart Failure
- ☐ Chronic Constipation/Indigestion
- ☐ Chronic Cough
- ☐ Chronic Fatigue Syndrome
- ☐ Chronic Headaches
- ☐ Chronic Painful Menstruation
- ☐ Degenerative Disc Disease
- ☐ Diabetes
- ☐ Emphysema
- ☐ Epilepsy
- ☐ Fibromyalgia
- ☐ Haemophilia
- ☐ Heart Attack
- ☐ Herniated Disc
- ☐ High Blood Pressure
- ☐ HIV
- ☐ Infectious Skin Conditions
- ☐ Joint Instability / Dislocations
- ☐ Kidney Infections / Stones
- ☐ Loss Of Sensation
- ☐ Low Blood Pressure
- ☐ Lupus
- ☐ Multiple Sclerosis
- ☐ Osteoporosis
- ☐ Pacemaker
- ☐ Paralysis Or Nervous System
- ☐ Parkinson's
- ☐ Phlebitis or Thrombosis
- ☐ Presence of Wires, Pins or Artificial Joints
- ☐ Shortness of Breath
- ☐ Skin Irritations/Chronic Acne
- ☐ Stroke
- ☐ Surgeries: When_____ Type_____
- ☐ Tb
- ☐ Vision Or Hearing Loss
- ☐ Other (Please Specify)

_____

_____

Signature_____

Date_____

Name_____ Date_____

Reason for today's massage? _____

Injuries? Type_____ When _____

Infections/ Inflammations_____

Skin irritations? / Warts? _____

Medications_____

Involvement with other health care practitioners? _____

Pregnancy?_____ Due date _____

Occupation_____ Date of birth_____

Doctor_____ Phone _____

How did you hear about us?

Any other information or problems connected with your massage needs?

Signature_____