

The information requested below will assist us in treating you safely. Feel free to ask any questions about it. All information below will remain confidential and will only be disclosed when permitted or required by law or when requested by you.

About You

| | |
|------------------|----------------|
| Client Name: | Date of Birth: |
| Mailing Address: | Daytime Phone: |
| | Evening Phone: |
| E-Mail: | Occupation: |

About This Visit

| | |
|---|---|
| Why are you seeking Massage Therapy | Is this treatment related to a: Motor Vehicle Accident <input type="radio"/> Yes <input type="radio"/> No WSIB Claim <input type="radio"/> Yes <input type="radio"/> No |
| Have you had Massage Therapy before? <input type="radio"/> Yes <input type="radio"/> No | Who referred you for Massage Therapy? |

Your Health

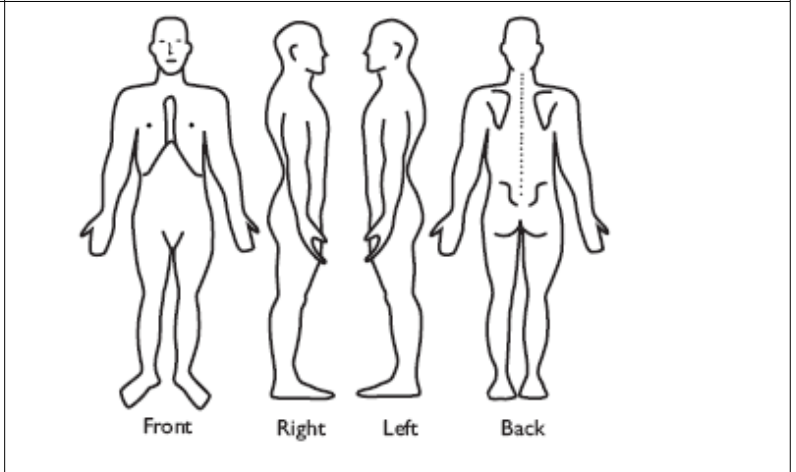
How is your overall health?

| | | | |
|--|--|--|-------------|
| Cardiovascular <input type="checkbox"/> High Blood Pressure <input type="checkbox"/> Low Blood Pressure <input type="checkbox"/> Chronic Congestive Heart Failure <input type="checkbox"/> Heart Attack <input type="checkbox"/> Phlebitis / Varicose veins <input type="checkbox"/> Stroke / CVA / TIA <input type="checkbox"/> Pacemaker or similar device <input type="checkbox"/> Heart disease <input type="checkbox"/> Family history of cardiovascular problems | Respiratory Conditions <input type="checkbox"/> Chronic cough <input type="checkbox"/> Shortness of breath <input type="checkbox"/> Bronchitis <input type="checkbox"/> Asthma <input type="checkbox"/> Emphysema <input type="checkbox"/> Family history of respiratory problems | Head and Neck <input type="checkbox"/> History of headaches <input type="checkbox"/> History of migraines <input type="checkbox"/> Vision problems <input type="checkbox"/> Vision loss <input type="checkbox"/> Ear problems <input type="checkbox"/> Hearing loss | |
| Infections <input type="checkbox"/> Hepatitis <input type="checkbox"/> Skin conditions <input type="checkbox"/> TB <input type="checkbox"/> HIV/AIDS <input type="checkbox"/> Herpes | Women <input type="checkbox"/> Pregnant <input type="checkbox"/> Gynaecological conditions | Other <input type="checkbox"/> Loss of sensation, tingling or numbness <input type="checkbox"/> Diabetes <input type="radio"/> Type 1 <input type="radio"/> Type 2 <input type="checkbox"/> Allergies / Hypersensitivity reactions <input type="checkbox"/> Epilepsy <input type="checkbox"/> Cancer <input type="checkbox"/> Arthritis | |
| Medications / Supplements / Vitamins | | Injuries / Accidents / Surgeries | |
| Name | Reason | Date | Description |
| | | | |
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| | | | |
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|---|--|
| Who is your primary care physician? | Are you currently receiving treatment from other health care professional? If yes, please describe. |
| Name: _____ | |
| Address: _____ | |
| Phone: _____ | |
| List any other medical conditions not identified above | Please indicate the locations of any artificial joints, pins or wires |

Mark the locations of any symptoms you are experiencing:

Circle -- painful locations
X – stiff locations
/// -- numbness, tingling



I certify that all the information provided is correct and complete. I understand and acknowledge that errors, or omissions, may effect the safety and/or efficacy of treatment.

Signature _____ Date: _____

| Date | Initials |
|------|----------|
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