



**Name:** \_\_\_\_\_  
**Address:** \_\_\_\_\_ **City:** \_\_\_\_\_  
**Province:** \_\_\_\_\_ **Postal Code:** \_\_\_\_\_ **Phone (h):** \_\_\_\_\_ **(w):** \_\_\_\_\_  
**E-mail Address (for appt reminders):** \_\_\_\_\_ Sign me up for monthly newsletter via email: Y / N  
**Current Date:** \_\_\_\_\_ **Referred By:** \_\_\_\_\_  
**Family Physician:** \_\_\_\_\_ **Address:** \_\_\_\_\_ **Phone:** \_\_\_\_\_  
**Emergency Contact:** \_\_\_\_\_ **Phone:** \_\_\_\_\_  
 Female  Male **Date of Birth** \_\_\_\_\_ **Occupation:** \_\_\_\_\_

**What is your general health status?** \_\_\_\_\_

**What is your dominant hand?**  Left  Right

**What is your primary sleeping position?**  Side  Front  Back

**Have you been physically or sexually abused in the past?**  No  Yes **Have you received counselling for this?** \_\_\_\_\_

**Are you currently taking ANY medication?**  No  Yes

*Please List Medications/Supplements:* \_\_\_\_\_ *Condition:* \_\_\_\_\_  
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**Are you, or are you possibly pregnant?**  No  Yes **Expected due date:** \_\_\_\_\_  
**Do you exercise regularly?**  No  Yes **Frequency x/week** \_\_\_\_\_

**What are your recreational activities?** \_\_\_\_\_

**Do you have any internal pins, wires, artificial joints or other special equipment?** (such as a pacemaker or a hearing aid)  No  Yes

If yes, please explain: \_\_\_\_\_

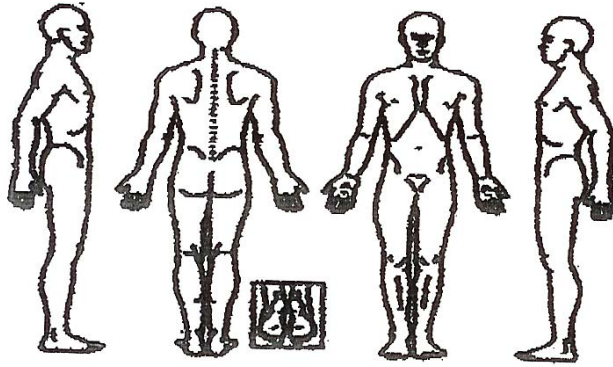
**Have you ever seen a Massage Therapist?**  No  Yes  
 If yes, what is their name? \_\_\_\_\_ When was your last treatment? \_\_\_\_\_

**Have you ever been in a motor vehicle accident, sustained an athletic injury or other trauma?**  No  Yes  
 Date: \_\_\_\_\_ Reason: \_\_\_\_\_  
 Date: \_\_\_\_\_ Reason: \_\_\_\_\_  
 Date: \_\_\_\_\_ Reason: \_\_\_\_\_

**Have you ever been hospitalized?**  No  Yes  
**Have you ever had surgery?**  No  Yes  
 Date: \_\_\_\_\_ Reason: \_\_\_\_\_  
 Date: \_\_\_\_\_ Reason: \_\_\_\_\_  
 Date: \_\_\_\_\_ Reason: \_\_\_\_\_

**What is the purpose of your visit?** \_\_\_\_\_  
**What started this condition?** \_\_\_\_\_  
**When did this condition begin?** \_\_\_\_\_  
**What aggravates this condition?** \_\_\_\_\_  
**What relieves this condition?** \_\_\_\_\_

**Have you received treatment from other healthcare providers for this condition?**  No  Yes  
 If yes, who are they and what type of healthcare provider are they? \_\_\_\_\_



← Please circle current symptomatic areas in your body on the diagrams (left).

Have you been diagnosed with, or have you ever experienced any of the following? If yes, please mark with an "X" in the box provided.

**Circulatory/Respiratory**

- Chronic congestive heart failure
- Heart disease
- Other heart condition
- High blood pressure
- Low blood pressure
- Varicose veins
- Phlebitis
- Deep vein thrombosis
- Raynaud's disease/phenomenon
- Buerger's disease
- Asthma
- Emphysema
- Shortness of breath
- Chronic cough
- Bronchitis

**Nervous System**

- Epilepsy
- Multiple Sclerosis
- Cerebral Palsy
- Parkinson's
- Nerve lesion
- Sciatica
- Carpal tunnel syndrome

**Musculoskeletal**

- Scoliosis
- Bone or joint disease
- Arthritis
- Joint instability
- Tendonitis
- Fractured bones
- Jaw pain (TMJ)
- Whiplash

**Skin**

- Sensitivities to oils, lotions, detergents
- Other allergies or hypersensitivities
- Irritated skin conditions
- Any Contagious conditions
- Lack of sensation

**General**

- Cancer/Tumours
- Undiagnosed lump
- Diabetes
- Kidney problems
- Liver problems
- Drug/Alcohol addiction or withdrawal
- Infections conditions (hepatitis/HIV/TB)
- Eating disorder
- Loss of vision or hearing

**Please list any other condition not listed and provide details if necessary:**

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**Have you ever suffered from:**

Heart attack:  No  Yes Date: \_\_\_\_\_

Stroke:  No  Yes Date: \_\_\_\_\_

I, \_\_\_\_\_ hereby declare that all of the above information is correct, and if it should change, it is my responsibility to notify the therapist of these changes at the next scheduled appointment.

Signature of Client: \_\_\_\_\_ Date: \_\_\_\_\_

Signature of Parent/Guardian (if applicable): \_\_\_\_\_ Date: \_\_\_\_\_