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Updates: _____

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:* _____

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? _____

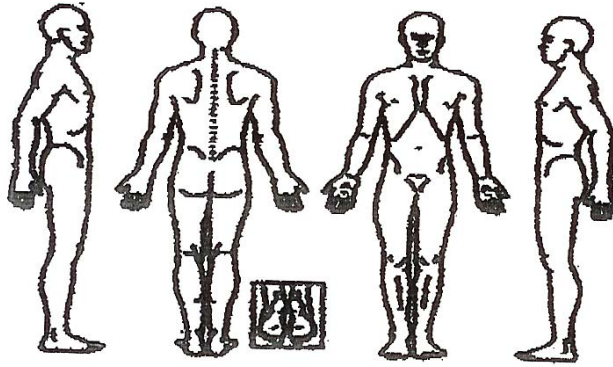
When did this condition begin? _____

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: _____