

CONFIDENTIAL CLIENT CASE HISTORY

NAME AGE DATE OF BIRTH (DD/MM/YY) GENDER

ADDRESS CITY POSTAL CODE

PHONE NUMBERS (HOME/CELL/WORK) EMAIL ADDRESS

PHYSICIAN'S NAME CLINIC HEALTH CARD NUMBER

CURRENT MEDICATIONS

OCCUATION EMPLOYER SPORTS & ACTIVITIES

REASON FOR TODAY'S TREATMENT

Have you been to a massage therapist before? Yes No Date of last treatment: _____

Are you under any medical supervision presently? Yes No

Are you Pregnant? Yes No How many weeks? _____ Due Date: _____

Did the current injury result form a Motor Vehicle Accident of Workplace Injury?

IF YES, WHAT IS YOUR SGI OR WCB CLAIM #

RCMP/VETERANS #

Are you under medical care for any of the following:

- | | | | |
|--|--|---|---------------------------------------|
| <input type="radio"/> Heart conditions | <input type="radio"/> Nervous disorders | <input type="radio"/> Asthma/respiratory | <input type="radio"/> Jaw or ear pain |
| <input type="radio"/> Varicose veins | <input type="radio"/> High/low blood pressure | <input type="radio"/> Pelvic inflammatory disease | <input type="radio"/> Skin conditions |
| <input type="radio"/> Neck injury | <input type="radio"/> Phlebitis/circulatory problems | <input type="radio"/> Whiplash | <input type="radio"/> Fibromyalgia |
| <input type="radio"/> Osteoporosis | <input type="radio"/> Back injury | <input type="radio"/> Osteoarthritis | <input type="radio"/> Epilepsy |
| <input type="radio"/> Cancer | <input type="radio"/> Rheumatoid arthritis | <input type="radio"/> Fainting or dizziness | <input type="radio"/> Other: _____ |
| <input type="radio"/> Diabetes | <input type="radio"/> Kidney disease | <input type="radio"/> Headaches or migraine | _____ |
| <input type="radio"/> Crohn's disease | | | _____ |

Have you received care from any of the following?

- | | | | |
|------------------------------------|---------------------------------------|----------------------------------|-----------------------------------|
| <input type="radio"/> Chiropractor | <input type="radio"/> Physiotherapist | <input type="radio"/> Naturopath | <input type="radio"/> Acupuncture |
| <input type="radio"/> Other: _____ | | | |

Have you had surgery in the past? Yes No

IF YES, FOR WHAT?

Have you had any fractures/sprains in the past? Yes No

IF YES, WHERE?

CONFIDENTIAL CLIENT CASE HISTORY

Have you had any serious illnesses in the past? Yes No

IF YES, WHAT?

Have you had any of the following regarding your current condition?

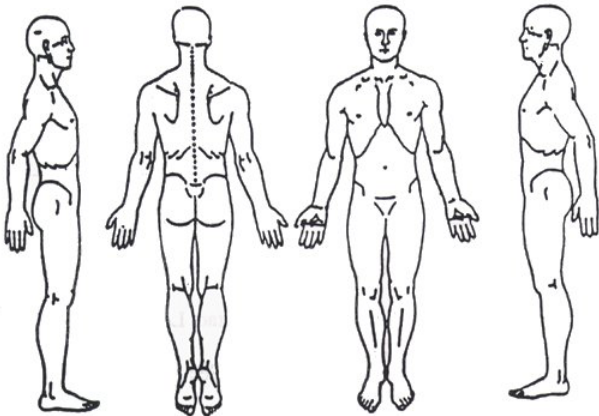
Physician's examination X-ray Other diagnostic tests such as CT, MRI, etc.

Do you have any allergies? Sensitivities? Yes No

IF YES, PLEASE LIST

What relieves your pain?

Please circle on the following diagram the affected areas of concern.



Missed Appointment / Cancellation Policy

Your appointment time is reserved especially for you. If you are unable to keep your allotted time, we require notification of **24 hours**. If you are unable to provide the required 24 hours, **Cancellations & Missed Appointments will be charged the FULL PRICE OF TREATMENT TIME** booked. Receipts will not be issued for missed or cancelled appointments. This fee is not redeemable through insurance companies for reimbursement.

Waiver

Because a Massage Therapist must be aware of existing physical conditions, I have stated all my known medical conditions and take it upon myself to keep the Massage Therapist updated on my physical and mental health. The information contained on this form is true to the best of my knowledge. I give my permission that my therapist may obtain and submit reports regarding my condition to/from my physician as may be required.

I understand and I am informed that in the practice of Massage Therapy, as in all other forms of health care, there are some risks to treatment including, but not limited to muscle soreness and stiffness. I acknowledge that I have the right at any time to ask any questions I may have regarding my treatment.

SIGNATURE OF PATIENT / GUARDIAN

DATE (YY/MM/DD)

WITNESS