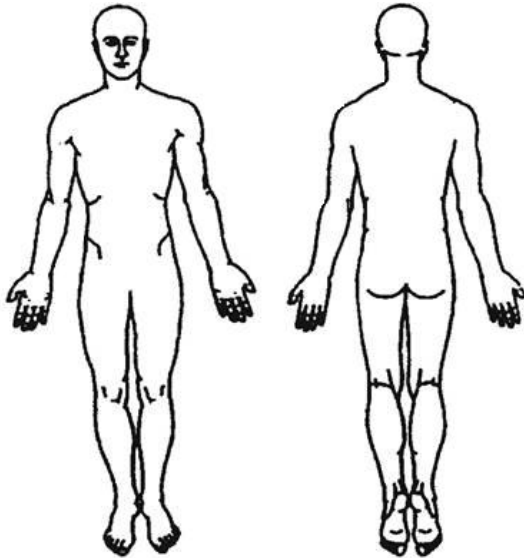


Massage Therapy

Last Name	First Name	D.O.B.	
Address	City	Province	Postal Code
Home Phone		Cell Phone	
Occupation		Employer	
Medical Doctor		Email	
Emergency contact		Phone Number	
How did you hear about our office? _____			
What are you seeking treatment for? _____			
How long has this condition been bothering you? _____			
Was this a motor vehicle accident or workplace injury? Y / N			

Problem Areas

Indicate areas of **pain, tension, numbness, tingling** or **swelling**



Have you ever been treated by:

- Chiropractor
- Massage Therapist
- Physiotherapist
- Acupuncture
- Naturopathic Doctor
- Osteopath
- Other: _____

If you are experiencing pain please specify a level on the scale
MILD 1...2...3...4...5...6...7...8...9...10 SEVERE

I, _____, consent to massage therapy treatments as described by the massage therapist. I also verify that the information given on this form is true and reflects my past and present health status. Should there be any changes in my health I will inform my therapist before treatment.

I understand that massage therapist do not diagnose illness or prescribe medications, and that my treatment will be in the context of relaxation, relief of muscular tension or pain, and improving circulation.

I agree to pay for all scheduled appointments that I am unable to keep unless I notify my massage therapist at least 24 hours in advance. Should I arrive late I will pay for a full session although it will end at the originally scheduled time.

Signed: _____ Date: _____

Please check all that apply:

Cardiovascular

- Stroke
- High Blood Pressure
- Low Blood Pressure
- Circulatory Disorders
- Varicose Veins
- Pacemaker
- Phlebitis
- Heart Disease
- Chronic Congestive Heart Failure
- Myocardial Infarction

Respiratory

- Emphysema
- Asthma
- Chronic Cough
- Bronchitis
- Breathing Difficulty
- Lung Disorder

Neurological

- Epilepsy
 - Multiple Sclerosis
 - Loss of Sensation
 - Neuritis
- other: _____
- _____

Digestive & Urinary

- Chronic Abdominal Pain
- Prolonged Constipation
- Frequent Urination
- Diarrhea
- Irritable Bowel Syndrome
- Ulcerative Colitis
- Pelvic Inflammatory Disease
- Gastritis
- Liver/Gall Bladder
- Kidney/ Bladder

Skin

- Easily Bruise
- Eczema/Psoriasis
- Rash
- Fungal infections
- Plantar warts

Head and Neck

- Headache
- Migraine
- Visual Disturbances
- Earaches
- Hearing Problems
- Teeth/ Jaw Pain
- Locked Jaw
- Sinus Pain
- Dizziness/ Vertigo

Male

- Haemorrhoids
- Prostate Problems
- Sexual Dysfunction
- Hernias

Female

- Menstrual Problems
- Pregnant: Term
- Menopausal Problems
- Endometriosis
- Previous C-Section

Other

- Diabetes
- Cancer
- HIV/AIDS
- Tuberculosis
- Hepatitis
- Osteoporosis
- Arthritis
- Anxiety
- Depression

Massage Therapy

- Allergies
- Carpel Tunnel Syndrome
- Insomnia
- Fainting
- Chronic Fatigue Syndrome
- Seasonal Affective Disorder
- Fibromyalgia
- Scoliosis
- Haemophilia

Soft Tissue & Joint

Complaints	Right or Left
Neck	R <input type="radio"/> L <input type="radio"/>
Shoulder	R <input type="radio"/> L <input type="radio"/>
Arm	R <input type="radio"/> L <input type="radio"/>
Chest	R <input type="radio"/> L <input type="radio"/>
Abdomen	R <input type="radio"/> L <input type="radio"/>
Upper Back	R <input type="radio"/> L <input type="radio"/>
Mid Back	R <input type="radio"/> L <input type="radio"/>
Lower Back	R <input type="radio"/> L <input type="radio"/>
Hip	R <input type="radio"/> L <input type="radio"/>
Leg	R <input type="radio"/> L <input type="radio"/>
Knee	R <input type="radio"/> L <input type="radio"/>
Ankle	R <input type="radio"/> L <input type="radio"/>
other:	_____

Surgical Implants

Pins, plates, wires, artificial joints:

Injuries

- Muscle Strain
 - Ligament Sprain
 - Fracture
 - Whiplash
 - Herniated Disc
- other:
