1065 Cambie Street Vancouver BC V6B 5L7 (604) 687-2900
Wellness and Rehabilitation Services

REGISTERED MASSAGE THERAPY

NAME: _____

ADDRESS_____
POSTAL CODE_____
EMAIL ADDRESS_____

DATE OF BIRTH_____
HOW DID YOU HEAR ABOUT US?_____
CARECARD#_____

DATE_____
( ) HOME NUMBER_____
( ) WORK NUMBER_____
( ) CELL NUMBER_____
For Emergencies, please check (✓) the best number above to reach you.

YOUR APPOINTMENT: Your appointment time is reserved especially for you. If you find it necessary to reschedule an appointment, a minimum of 24 hours' notice is required so we may allow others to utilize this time. Otherwise it will be necessary to charge you the full amount of your scheduled appointment fee. Thank you for your cooperation and understanding.

_____ **Initials**

Reason for appointment:_____
_____

PLEASE LIST AND DATE: Any diagnosed medical conditions:_____
_____

Accidents/Injuries/Illness_____
_____
Surgical Procedures:_____
_____
Do you take Medications? (Daily, weekly, monthly) Please list the medications and what they are for:_____
_____
List any ALLERGIES:_____
_____
Have you had a professional massage before?_____
Other health professional visits? Chiropractor_____ Naturopath____ Physiotherapist_____
Other_____Are you interested in a Consultation with a Chiropractor?_____
Please describe Occupation:_____ Continual posture?_____
Repetitive Movements (describe)?_____
How is your overall health (mental, emotional, and physical)?_____

Have you had a major change in the last year? (If so, please describe)_____
_____
What is your major source of stress?_____
How would you describe: Your energy level?_____ Sleep pattern:_____
Diet?_____ Water intake(# of cups)_____

Do you use any of the following? **D**aily **O**ften **I**nfrequently **N**ever
Cigarettes:_____ Coffee:_____ Alcohol:_____ Carbonated Drinks:_____ Pain Meds:_____

Please mark X for conditions that apply now. P = Past F = Family History

Neck/Back Pain	Rib Pain	Aching Muscles/Joints
Limited Joint Movement	Artificial Joint/Steel Pin	Painful/Swollen Joints
Osteoarthritis	Rheumatoid Arthritis	Fractures
Kidney Disorders	Painful Menstruation	Pregnant (or possibility)
Menopause	Nausea/Vomiting	Problems swallowing
Abdominal Pains	Heartburn	Headaches
Migraines	Whiplash	Neck Tension
Ear Ache/Infection	Hearing Problems	Frequent Anxiety/Fear
Depression	Muscle Weakness	Paralysis
Numbness	Tingling	Epilepsy
Skin Infection	Skin Conditions	Emphysema
Asthma	Dizziness/Fainting	Shortness of Breath
Heart Disease/Conditions	Stroke	Edema (swelling)
Chest Pains	Low Blood Pressure	High Blood Pressure
Varicose Veins	Bruise Easily	Cold Hands/Feet

General

Aids/HIV	Cancer
Diabetes	Fibromyalgia
Multiple Sclerosis	Spinal Misalignments

I am responsible for my health and I understand that all appointments I book at this clinic are especially reserved for me and that I am responsible for payment of all services rendered. A late charge will be applied to accounts for missed appointments unless 24 hours' notice of cancellation is given. Initials _____

If you have Extended Health Insurance, we are happy to assist you with providing receipts. However, I understand that it is the patient's responsibility to ensure coverage. Initials _____

I consent to electronic communications from this office. I understand that I may opt out of this at anytime. Initials _____

SIGNATURE_____ DATE_____