



Date: _____

Name: _____ Phone #: (H) _____ (Work or Cell) _____
 Address: _____ City: _____ Province: _____
 Postal Code: _____ Gender: M _____ F _____ Birth date (M) _____ (D) _____ (Y) _____
 Doctor: _____ Directed to clinic by: _____

Are you presently on an ICBC, WCB or disabilities Claim: Yes ___ No ___
 If so: Claim #: _____ Date of Accident: _____
 Care card #: _____ Billing #: _____
 Adjuster's Name: _____ Phone #: _____
 Adjuster's Address: _____ Fax #: _____
 Lawyer's Name: _____ Phone #: _____

Reason for appointment: _____
 What makes the condition worse or better? _____
 Have you had this condition in the past? How was it resolved? _____

Please LIST AND DATE: Any diagnosed medical conditions: _____

 Accidents/ Injuries / Illness: _____

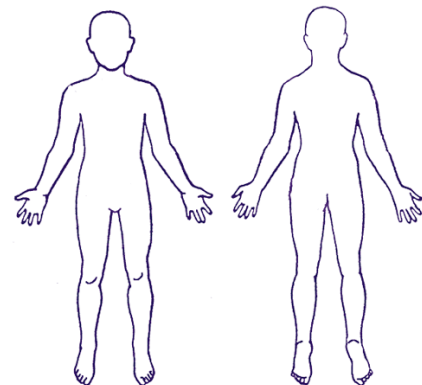
 Surgical Procedures: _____

Do you take Medications? (Daily, Weekly, Monthly) Please list the medications and what they are for:

PLEASE LIST ANY SENSITIVITIES OR ALLERGIES (I.E. Latex) _____
 Have you had a professional massage before? _____ Spa treatment? _____
 Are you also seeing a: Chiropractor _____ Physiotherapist _____ Naturopath _____ Other _____
 Please describe: Occupation: _____
 Repetitive movement: _____
 Please list all forms and frequency of exercise, sports, and hobbies: _____

Please describe your: major source of stress? _____ Energy level: _____
 Sleep pattern: _____ Diet: _____ water intake: _____

Please label any areas of discomfort on the diagram provided



Please Mark: 'X' for conditions that apply now. P= Past F=Family History

Musculo- skeletal		Head/ Neck		Cardiovascular	
Neck/Back Pain		Headaches		Heart palpitations	
Rib Pain		Migraines		Dizziness/fainting	
Aching Muscles/ joints		Facial nerve pain		Thrombosis	
Limited joint movement		Torticollis		Shortness of breath	
Artificial joint/steel pins		Thyroid condition		Heart attack	
Painful/swollen joints		Lumps in neck		Rheumatic fever	
Cracking in joints		Whiplash		Heart disease/condition	
Pain when walking		Neck tension		Stroke	
Muscle cramps		Ear ache/infection		Edema (swelling)	
Osteoarthritis		Hearing problem		Chest pains	
Rheumatoid arthritis		TMJ disorder		Aneurysm	
Bursitis				Arteriosclerosis	
Tendonitis		Nervous system			
Frozen shoulder		Frequent anxiety or fear		Circulatory system	
Fractures		Frequent anger		Phlebitis	
Disc problem/herniation		Irritability		Low blood pressure	
Spinal problem		Depression		High blood pressure	
Scoliosis		Muscle weakness		Anemia	
		Sciatic problem		Varicose veins	
Genito-urinary		Paralysis		Blood disorder	
Painful/frequent urination		Numbness		Excessive bleeding	
Bladder infection		Tingling		Hemophilia	
Kidney disorders		Unusual sensation		Bruise easily	
Kidney stones		Epilepsy		Currently bruised	
Painful menstruation		Fatigue		Frequent cold hands and feet	
Irregular menstruation				Gout	
Pregnant or possibility		Skin			
Pelvic infection		Skin infection		General	
Menopause		Itching/ dryness		Hep A, B, C or Other	
		Psoriasis		AIDS/ HIV	
Digestive System		Eczema		Insomnia	
Poor appetite		Skin disorder/condition		Cancer	
Gas or bloating		Plantar warts		Polio	
Constipation		Open sore/ wound		Herpes	
Diarrhea				Obesity	
Indigestion		Respiratory		Diabetes type I or II	
Hemorrhoids		Sinus irritation		Parkinson disease	
Nausea/vomiting		Swollen glands		Cerebral palsy	
Problems swallowing		Emphysema		Fibromyalgia	
Abdominal pain		Asthma		Multiple sclerosis	
Heartburn		tuberculosis		Seizures	
Ulcers				Current fever	
Abdominal cyst or tumor				inflammation	
Liver disorders				Infection	

Cancellation Agreement

24 Hours notice is required to cancel or change an appointment. I agree to pay 50% of the total treatment fee if I do not give the required 24 hours notice. (Exceptional circumstances are considered)

I have read the above information and certify it to be true and correct to the best of my knowledge.

Signature: _____ Date: _____