CONFIDENTIAL CLIENT INFORMATION and HEALTH HISTORY

1218 Lorette Avenue, Winnipeg, Manitoba R3M 1W5

Name: _____

Address: _____ Postal Code: _____

Phone: Res: _____ Work: _____ Cel: _____

Email Address: _____ Date of Birth: _____

Occupation: _____ How did you learn of the clinic: _____

Have you seen a massage therapist before? _____ If yes, when was your last massage? _____

What are your goals for the massage treatment? _____

Is your visit the result of an accident/injury? _____ Date of accident/injury _____

How did your accident/injury occur? _____

_____

Please list any previous motor vehicle or other injuries _____

Are you under medical supervision? (If yes, explain) _____

Medical Doctor Name: _____ Phone No.: _____

Chiropractic Doctor Name: _____ Phone No.: _____

Other Health Care Practitioners: _____

Medication: Prescription: _____

Why?: _____

Non Prescription: _____

Allergies: ☐ Yes ☐ No If yes, to what _____

Prosthesis _____ Pins _____ Plates _____

Lifestyle:

Stress Level ☐ Low ☐ Medium ☐ High Cause: _____

Exercise What kind?: _____ How often?: _____

Sleep: ☐ Poor ☐ Average ☐ Fine

Sleep Position: ☐ Right Side ☐ Left Side ☐ Back ☐ Abdomen

Please indicate with a check mark if you currently have any of the following conditions and with an 'x' if you have had them within the last 5 years.

Cardiovascular:
- Chest Pain/Palpitations ☐
- Dizziness/Fainting ☐
- High Blood Pressure ☐
  - Treated with medication? ☐
- Low Blood Pressure ☐
- Varicose Veins ☐
- Pacemaker ☐
- Stroke/TIAs ☐
- Hemophilia ☐
- Cold Intolerance ☐
- Other _____ ☐

Gastrointestinal:
- Indigestion ☐
- Diarrhea/Constipation ☐
- Hepatitis ☐
- Other _____ ☐

Integumentary:
- Eczema ☐
- Psoriasis ☐
- Athletes Foot ☐
- Warts/Moles ☐
- Sensitive Skin ☐
- Rashes ☐

Respitory:
- Shortness of Breath ☐
- Sinus Problems ☐
- Asthma ☐
- Emphysema ☐
- Other _____ ☐

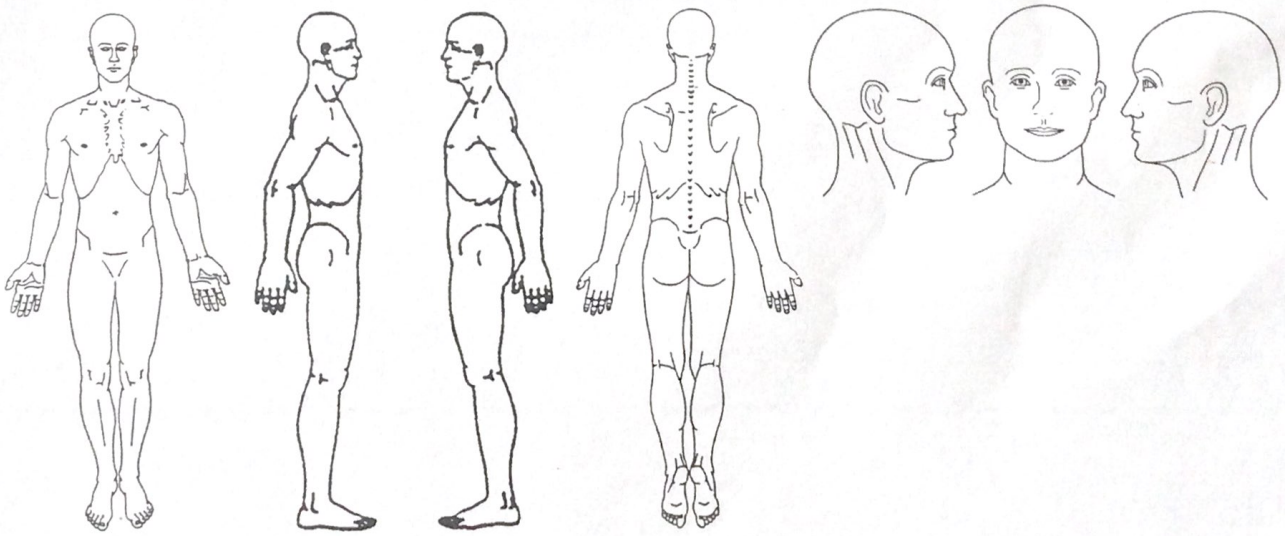
Nervous:
- Anxiety ☐
- Epilepsy ☐
- Neuromuscular Disorder ☐
  - Type? _____ ☐
- Shingles ☐
- Neuritis ☐
- Other _____ ☐

Systemic Disorders:
- Cancer ☐
  - Currently being treated? ☐
- Diabetes ☐
  - Insulin? ☐
- Anemia ☐

Uro-genital:
- Menstrual Pain ☐
- Menopause ☐
- Kidney/Bladder ☐
- Pregnant ☐
  - Due Date? _____ ☐

Musculoskeletal:
- Headaches ☐
  - Types? _____ ☐
  - Frequency? _____ ☐
  - Location? _____ ☐
- Dislocations ☐
- Tendonitis ☐
  - Location? _____ ☐
- Sprains ☐
  - Location? _____ ☐
- Muscle Cramps ☐
- Pain/Difficulty Walking ☐
- Fibromyalgia ☐
- TMJ ☐
- Arthritis ☐
  - Type? _____ ☐
- Sciatica ☐
- Carpal Tunnel Syndrome ☐
- Plantar Fascitis ☐
- Burstitis ☐
- Other _____ ☐

Please indicate the areas of your pain:



Consent Form for Massage Therapy

1218 LORETTE AVENUE, WINNIPEG, MANITOBA R3M 1W5

Denise Pauls, RMT **Leona Schwarz, RMT**

Michelle McCorrister, RMT **Dawna Smith, RMT**

My signature indicates my consent for massage therapy treatment. I understand massage therapy is not intended to be a substitute to the medical advice of my physician. I have stated all of my medical conditions to the best of my knowledge. I give permission for my massage therapist to communicate with my physician(s) or other health care provider if in discussion with me, it is agreed upon.

I understand that the charges of my massage therapy may not be covered by or exceed my policy benefits. I understand that I am financially responsible to my therapist for the cost of the treatment and am responsible to track my insurance usage.

I also understand that missed appointments or appointments cancelled without 24 hours notice (some exeptions may apply) may be charged in full.

_____ _____

CLIENT SIGNATURE DATE