First Name	Last Name	Sex	Date of Birth	Street #	Unit #	Street Address

City	Prov	Postal Code	Home Phone	Work Phone	Mobile
Email		Would you like to be added to our email list? YES☐ NO☐		Employer	Do you have Health Benefits? YES ☐ NO☐
Family Physician	Phone		Emergency Contact	Relation	Phone
Have you received Massage Therapy treatments before? YES☐ NO☐		Present involvement in other Health Care? YES☐ NO ☐		Preferred booking time, for our records: 8-11am / 12-1pm / 2-5pm /6-9pm	
General Health Status		Primary Complaint		Source of Referral (Physician/Friend)	

HEALTH INFORMATION: Please Indicate ☑ conditions that you are experiencing or have experienced.

Soft Tissue/Joints	Circulatory/Respiratory	Digestive	Reproductive	Neurological
☐Headaches	☐Dizziness	☐Ulcers	☐PMS	☐Numbness/Tingling
☐Neck	☐Shortness of breath	☐Indigestion	☐Pre-menopause	☐Facial Twitching
☐Shoulder	☐Chronic cough	☐Constipation	☐Menopause	☐Chronic pain
☐Upper back	☐Allergies	☐Bloated	☐Pelvic inflammation	☐Sleeping difficulty
☐Mid back	☐Sinus problems	☐Diarrhea	☐Endometriosis	☐Paralysis
☐Low back	☐Asthma	☐Diverticulitis	☐Hysterectomy	☐Cerebral palsy
☐Arms	☐Bronchitis	☐IBS	☐Fertility concerns	☐Epilepsy
☐Hip	☐Emphysema	☐Colitis	☐Prostate problems	☐Multiple sclerosis
☐Legs	☐Fainting	☐Crohn's disease	☐Pregnancy/due date:	☐Muscular dystrophy
☐Knees	☐Cold feet/hands	☐Adaptive aids		☐Spinal cord injury
☐Ankles	☐Swollen ankles		Infection Disease	☐Herpes/Shingles
☐Jaw/TMJ	☐Varicose veins	Skin	☐Hepatitis	☐Fatigue/Chronic fatigue
☐Bursitis	☐Blood Clots	☐Rashes	☐Infections skin conditions	
☐Arthritis	☐Stroke	☐Allergies	☐Tuberculosis	Family History
☐Joint stiffness	☐Chest pain	☐Athlete's foot	☐HIV	☐Cancer
☐Spasms/Cramps	☐Heart condition	☐Warts	☐Other:	☐High Cholesterol
☐Fracture bone	☐Low blood pressure	☐Moles		☐Heart Disease
☐Osteoporosis	☐High blood pressure	☐Acne		☐Hypertension
☐Osteopenia	☐Hypertension	☐Bruise easily		☐Stroke
☐Scoliosis	☐High cholesterol	☐Loss of sensation		☐Diabetes
	☐Lymphedema			☐Other:

I have read the above information and have stated all my previous and current medical conditions. I take upon myself to update My Treatment Space regarding any changes in my condition. I understand that all massage treatments will be discussed and planned with the Massage Therapist, and will require my informed consent.

Today's Date	**Print Name**	**Signature**