Client Health History

Name:_______________________ Today's Date:_______________________

Address:_______________________ City:_______________________

Postal Code:_______________________ Phone:_______________________

Email: _______________________ Date of Birth:_______________________

Would you like to sign up for my FREE client e-newsletter and receive my free report:

'21 ways to break the chronic pain cycle'? □Yes □No

Occupation & related duties:_______________________

BC Medical Care Card number (PHN): _______________________

Doctor:_______________________ Phone:_______________________ May I contact? □Yes □No

Emergency contact person: _______________________ Phone:_______________________

Do you presently have an insurance claim with **ICBC**? □Yes □No OR a **WorkSafe BC** claim? □Yes □No

If yes, please indicate claim number: _______________ and case worker_______________________

Before I ask you about your discomfort, tell me, what in your life brings you Joy?

____

____

What are your goals in receiving massage therapy today? (please check all that apply)

relaxation / stress reduction   injury rehabilitation   chronic pain relief   sports training

maintain wellness   other _______________________

Please CIRCLE the answer closest to how you PRESENTLY feel: (1 = poor, 5 = excellent)

Quality of sleep	1	2	3	4	5
Energy level	1	2	3	4	5
Exercise habits	1	2	3	4	5
Stress management	1	2	3	4	5
Eating habits	1	2	3	4	5

Have there been any significant changes in your life in the past 6 months to 1 year? If yes, please describe:

____

____

Are you presently happy with how your body is serving you? Yes□ No□

If not, what would you like to improve? _______________________

____

Please mark an "X" beside any conditions which are currently disrupting your life, or mark a "P" if it was an issue in your past:

HEAD / NECK:

__headaches
__sinus infections
__vision problems
__neck pain
__ringing in ears
__jaw pain
__hearing loss
__Other:____________________

CARDIOVASCULAR:

__high blood pressure
__chest pain
__low blood pressure
__stroke
__poor circulation
__phlebitis
__heart disease
__varicose veins
__Other:______________________

MUSCLES / JOINTS:

__disc problems
__ bursitis
__arthritis: where?_________________
__ tendonitis: where?_______________
__ dislocation: where?______________
__ fracture: where?_________________
__ osteoporosis

DIGESTIVE PROBLEMS:

__ please describe: _________________
____

RESPIRITORY:

__asthma
__chest pain
__bronchitis
__emphysema
__hay fever
__pneumonia
__Other:_________________________

SKIN:

__sensitive skin
__warts
__bruise easily
__athlete's foot
__eczema
__rash / hives
__psoriasis
__other___________

NERVOUS/ENDOCRINE:

__dizziness or fainting
__numbness/tingling
__anxiety
__sleep disorders
__depression
__muscle jerking
__seizures
__chronic fatigue syndrome
__thyroid dysfunction
__fibromyalgia
__Other:____________________

REPRODUCTIVE:

__painful or irregular menstruation
__menopause
__pregnant?
If current, how many weeks?________
If past, how many pregnancies?______
__prostate problems
__Other:_______________________

URINARY:

__bladder infection
__kidney stones
__other ______________________

Please indicate any other major illnesses, injuries or surgeries that you have experienced: ____

____

Current medications & supplements:

____

____

Cascade
massage therapy

PAIN DIAGRAM

Please mark an "X" or circle over the areas you experience pain or discomfort.

IF CHRONIC PAIN IS YOUR CONCERN, PLEASE COMPLETE THE FOLLOWING:

On the line provided, please mark where your "pain status" is <u>today</u>:

No pain — Most severe pain

On the line provided, please mark where your "pain status" was <u>when it was at its most severe:</u>

No pain — Most severe pain

Please read and sign for consent to massage therapy by Sonja Rawlings, RMT, RA, EOT.
I confirm that the information I have provided is true and complete to the best of my knowledge. I understand that the above information and the details of my massage therapy treatments are confidential and will not be released without my written consent, unless otherwise required by law. I consent to receive integrative massage therapy from Sonja Rawlings, RMT, RA, EOT. I understand that I am responsible for payment upon receipt of service and that in order to receive partial or complete reimbursement from a 3rd party insurance provider, I must submit my massage therapy receipts to the provider directly. I agree to provide a minimum of 24 hours notice when cancelling an appointment or 50% of charges will apply.

______________________________ Client Signature

______________________________ Today's Date