Cascade massage therapy

Client Health History

Name:_____ Today's Date:_____

Address:_____ City:_____

Postal Code:_____

Phone: Home_____ Work_____ Cell _____

Email: _____ Date of Birth:_____

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 ☐surgery (pre or post op) support

☐ chronic pain relief ☐ managing chronic illness ☐ 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

Occupation & related duties:

_____

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? _____

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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:

_____

_____

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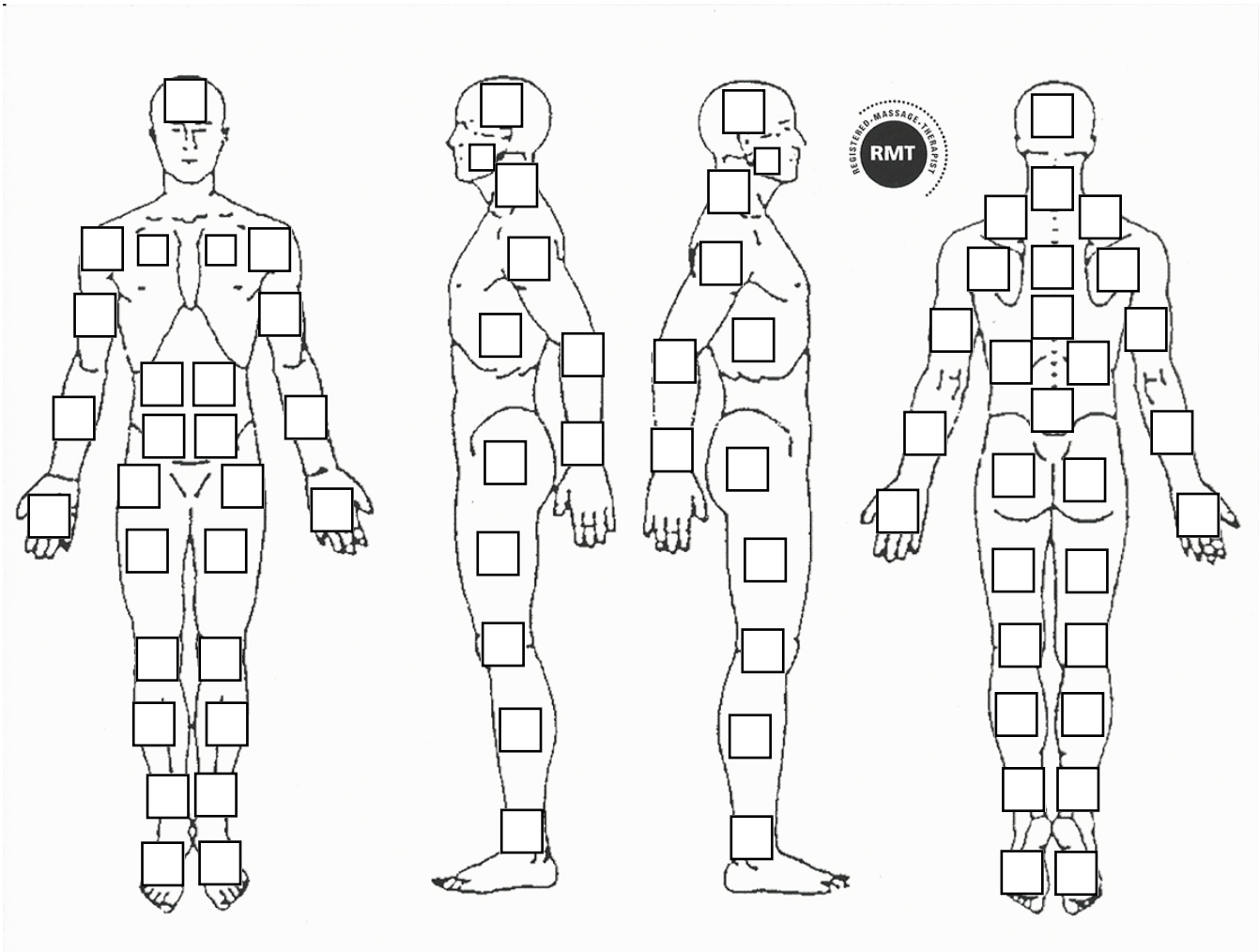
Please mark the approximate areas you experience pain or discomfort.



Please read and sign for consent to massage therapy by Sonja Rawlings, RMT.
I confirm that the information I have provided about myself 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 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.

Signature: _____ Printed Name: _____

Today's Date: _____