



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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<p>HEAD / NECK:</p> <p><input type="checkbox"/> headaches <input type="checkbox"/> sinus infections</p> <p><input type="checkbox"/> vision problems <input type="checkbox"/> neck pain</p> <p><input type="checkbox"/> ringing in ears <input type="checkbox"/> jaw pain</p> <p><input type="checkbox"/> hearing loss</p> <p>Other: _____</p>	<p>CARDIOVASCULAR:</p> <p><input type="checkbox"/> high blood pressure <input type="checkbox"/> chest pain</p> <p><input type="checkbox"/> low blood pressure <input type="checkbox"/> stroke</p> <p><input type="checkbox"/> poor circulation <input type="checkbox"/> phlebitis</p> <p><input type="checkbox"/> heart disease <input type="checkbox"/> varicose veins</p> <p>Other: _____</p>
<p>MUSCLES / JOINTS:</p> <p><input type="checkbox"/> disc problems</p> <p><input type="checkbox"/> bursitis</p> <p><input type="checkbox"/> arthritis: where? _____</p> <p><input type="checkbox"/> tendonitis: where? _____</p> <p><input type="checkbox"/> dislocation: where? _____</p> <p><input type="checkbox"/> fracture: where? _____</p> <p><input type="checkbox"/> osteoporosis</p> <p>DIGESTIVE PROBLEMS:</p> <p><input type="checkbox"/> please describe: _____</p> <p>_____</p>	<p>RESPIRATORY:</p> <p><input type="checkbox"/> asthma <input type="checkbox"/> chest pain</p> <p><input type="checkbox"/> bronchitis <input type="checkbox"/> emphysema</p> <p><input type="checkbox"/> hay fever <input type="checkbox"/> pneumonia</p> <p>Other: _____</p> <p>SKIN:</p> <p><input type="checkbox"/> sensitive skin <input type="checkbox"/> warts</p> <p><input type="checkbox"/> bruise easily <input type="checkbox"/> athlete's foot</p> <p><input type="checkbox"/> eczema <input type="checkbox"/> rash / hives</p> <p><input type="checkbox"/> psoriasis <input type="checkbox"/> other _____</p>
<p>NERVOUS/ENDOCRINE:</p> <p><input type="checkbox"/> dizziness or fainting</p> <p><input type="checkbox"/> numbness/tingling</p> <p><input type="checkbox"/> anxiety</p> <p><input type="checkbox"/> sleep disorders</p> <p><input type="checkbox"/> depression</p> <p><input type="checkbox"/> muscle jerking</p> <p><input type="checkbox"/> seizures</p> <p><input type="checkbox"/> chronic fatigue syndrome</p> <p><input type="checkbox"/> thyroid dysfunction</p> <p><input type="checkbox"/> fibromyalgia</p> <p>Other: _____</p>	<p>REPRODUCTIVE:</p> <p><input type="checkbox"/> painful or irregular menstruation</p> <p><input type="checkbox"/> menopause</p> <p><input type="checkbox"/> pregnant?</p> <p>If current, how many weeks? _____</p> <p>If past, how many pregnancies? _____</p> <p><input type="checkbox"/> prostate problems</p> <p>Other: _____</p> <p>URINARY:</p> <p><input type="checkbox"/> bladder infection</p> <p><input type="checkbox"/> kidney stones</p> <p><input type="checkbox"/> other _____</p>

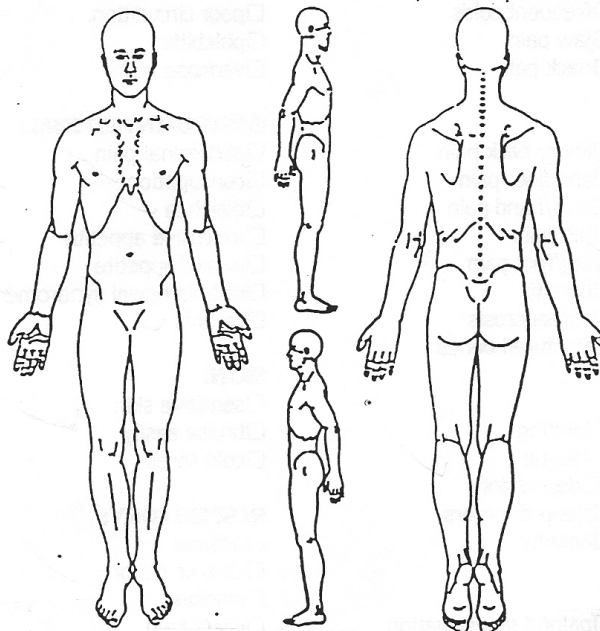
Please indicate any other major illnesses, injuries or surgeries that you have experienced: _____

Current medications & supplements:

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PAIN DIAGRAM

Please mark an "X" or circle over the 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: _____