

Please complete this form in full. All information is strictly confidential.

General Information

Name: _____ Date: _____
 Address: _____ Birth Date: _____
 City: _____ Province: _____ Postal Code: _____
 Preferred Phone: _____ Alternate Phone: _____
 Height: _____ Weight: _____ Max. Weight: _____ When: _____
 Occupation: _____ Have you had massage before: _____
 How did you hear about our clinic? _____

Focus *List major complaints in order of importance.*

Complaint	Since	Causes

Review of Symptoms *Only mark if a problem, 1=occasional difficulty 2=frequent difficulty 3=regular difficulty*

- | | | |
|--|--|---|
| 1 2 3 | 1 2 3 | 1 2 3 |
| <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> weight loss or gain | <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> fevers | <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> gas |
| <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> fatigue | <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> dizziness | <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> abdominal pain |
| <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> hair loss | <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> ringing in ears | <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> nausea/vomiting |
| <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> sexual difficulties | <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> earaches | <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> difficult digestion |
| <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> poor endurance | <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> blurry vision | <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> fatty foods aggravate |
| <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> confusion | <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> eyestrain | <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> constipation |
| <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> nervousness | <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> nasal congestion | <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> diarrhea |
| <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> depression | <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> sinus pressure | <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> thin stool |
| <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> insomnia | <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> nosebleeds | <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> straining |
| <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> nightmares | <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> hayfever | _____ number of bowel |
| <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> muscle tension | <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> swollen glands | _____ movements daily |
| <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> muscle cramps | <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> mucous problems | _____ is this a change (y/n) |
| <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> numbness/tingling | <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> sores in mouth | <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> hemorrhoids |
| <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> cold hands/feet | <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> coated tongue | <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> bloody or black stools |
| <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> sweaty hands/feet | <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> bad breath | <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> night urination |
| <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> blackouts | <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> sore throats | <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> urinary problems |
| <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> itching | <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> dental problems | <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> burning on urination |
| <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> rashes | <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> neck pains | <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> bladder/kidney infection |
| <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> acne | <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> cough | <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> bedwetting |
| <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> eczema | <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> difficult breathing | <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> blood in urine |
| <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> psoriasis | <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> shortness of breath | <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> back pains |
| <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> warts | <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> coughing blood | <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> leg swelling |
| <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> change in mole | <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> heart palpitations | <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> bone or joint pain |
| <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> bruise easily | <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> chest pains | <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> arm/leg problems |
| <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> headaches | <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> breast lumps/pain | <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> joint swelling |

Other: _____

Medical History

Personal Physician: _____ Telephone: _____

Date of last physical: _____

Are you pregnant? _____ What is your due date? _____

Are you allergic to medicines? Which ones? _____

Are you allergic to foods? Which ones? _____

Are you allergic to the environment? What? _____

Please list any regular medications, prescriptions or over the counter, that you take: _____

Please list any regular vitamin, mineral or herbal supplements you take: _____

Please list any major operations you have had, and the year: _____

Please list any major injuries or accidents that you have had, and the year: _____

Please list any major illnesses or hospitalizations that you have had, and the year: _____

Write the approximate year that you have incurred any of the following conditions:

- | | | | |
|-------------------------|---------------------|------------------------|-----------------------|
| _____ anemia | _____ drug reaction | _____ hypoglycaemia | _____ parasite |
| _____ arthritis | _____ eczema | _____ jaundice | _____ pneumonia |
| _____ asthma | _____ emphysema | _____ kidney infection | _____ psoriasis |
| _____ bladder infection | _____ epilepsy | _____ kidney stones | _____ rheumatic fever |
| _____ blood transfusion | _____ gallstones | _____ LB pressure | _____ skin boils |
| _____ bronchitis | _____ heart attack | _____ measles, German | _____ syphilis |
| _____ cancer | _____ heart disease | _____ measles, regular | _____ tuberculosis |
| _____ chicken pox | _____ hepatitis | _____ mental problems | _____ ulcer |
| _____ colitis | _____ HB pressure | _____ migraines | _____ whooping cough |
| _____ diabetes | _____ HIV/AIDS | _____ mumps | |
| _____ diphtheria | _____ hives | _____ obesity | |

Any other medical diagnosis you have from the past or present: _____

Exercise Information

How often do you exercise weekly? _____

What form of exercise? _____

How long do you exercise? _____

I certify that the information given in this form is true and accurately reflects my past and present health status.

Client's Signature _____

Date _____