

Body Aware Wellness Centre

CONFIDENTIAL CLIENT INFORMATION

PLEASE COMPLETE BOTH SIDES AND BRING WITH YOU TO YOUR APPOINTMENT

DATE _____ EMAIL ADDRESS _____
NAME _____ PHONE (RES) _____
ADDRESS _____ PHONE (BUS) _____
CITY/TOWN _____ POSTAL CODE _____
BIRTHDATE _____ AGE _____ SEX: M F
OCCUPATION _____ EMPLOYER _____
RECOMMENDED BY _____

DO YOU HAVE INSURANCE COVERAGE FOR MASSAGE THERAPY YES NO

INSURANCE COMPANY NAME _____

HAVE YOU HAD PREVIOUS MASSAGE THERAPY YES NO

WHERE _____ DID IT HELP YOUR CONDITION YES NO

YOUR MEDICAL DOCTORS NAME _____

PURPOSE OF THIS APPOINTMENT (YOUR MAJOR COMPLAINT) _____

HOW LONG HAVE YOU BEEN BOTHERED BY THESE SYMPTOMS _____

DESCRIBE _____

IS THIS CONDITION INTERFERING WITH YOUR WORK SLEEP DAILY ROUTINE

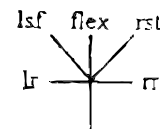
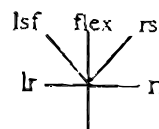
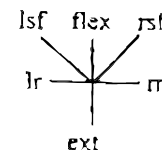
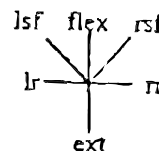
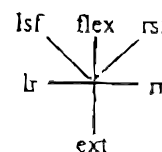
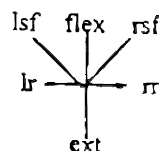
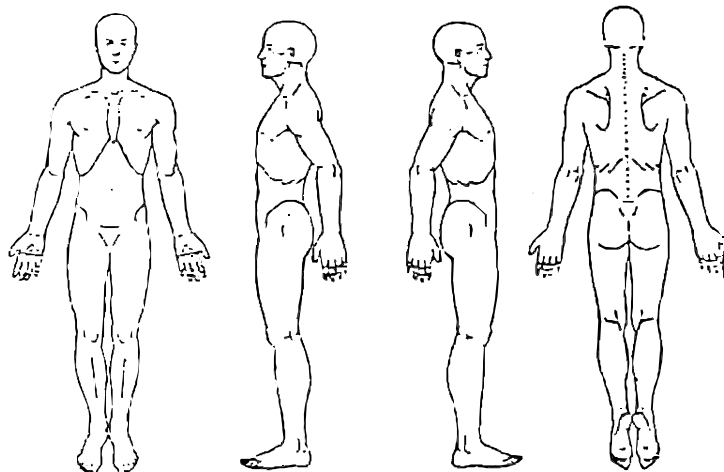
IS THIS CONDITION PROGRESSIVELY GETTING WORSE YES NO CONSTANT COMES AND GOES

WHAT AGGRAVATES YOUR CONDITION _____

WHAT RELIEVES YOUR CONDITION _____

Please shade in the areas where you experience problems or have concerns

OFFICE USE ONLY



HAVE YOU EVER HAD PHYSIOTHERAPY FOR THIS CONDITION YES NO

IF YES, WHICH CLINIC, THERAPIST AND WHY _____

ARE YOU NOW TAKING PHYSIOTHERAPY YES NO

BRIEFLY EXPLAIN THE TREATMENT _____

HAVE YOU EVER BEEN UNDER CHIROPRACTIC CARE FOR THIS CONDITION YES NO

IF YES, WHICH CLINIC OR CHIROPRACTOR _____

ARE YOU NOW UNDER CHIROPRACTIC CARE YES NO

ARE YOU TAKING ANY MEDICATIONS THAT YOUR MASSAGE THERAPIST SHOULD BE AWARE OF _____

DO YOU HAVE ANY OF THESE CONDITIONS

HEADACHE

FATIGUE

BACK PAIN

NERVOUSNESS/DEPRESSION

NECK PAIN/STIFFNESS

STRESS

SPINAL CURVATURE

ALLERGIES

POOR POSTURE

ASTHMA

SCIATICA

DIABETES

ARTHRITIS

CANCER

VARICOSE VEINS

DIGESTIVE DISORDERS

HIGH BLOOD PRESSURE

SKIN DISORDERS

POOR CIRCULATION

NUMBNESS/TINGLING (WHERE) _____

DO YOU WEAR CONTACTS YES NO

IS THERE ANYTHING ELSE YOU FEEL IS IMPORTANT FOR YOUR MASSAGE THERAPIST TO BE AWARE OF? PLEASE COMMENT _____

I understand massage therapy is given here for the purpose of stress reduction, relief from muscular tension, spasm or pain, or for increased circulation or energy flow. I understand the therapist does not diagnose illness, disease, or any other physical or mental disorder. It has also been made clear to me that massage therapist is not a substitute for a medical examination or a diagnosis and that it is recommended I see a physician for any physical ailment I might have. I hereby give permission to release information that may be required during the course of my treatment to my insurance company or attorney.

_____ (PLEASE SIGN)