MASSAGE & THERAPY CENTRE

ALL THERAPISTS
ARE REGISTERED

Therapist's Initials:____________________

CONFIDENTIAL MEDICAL HISTORY

NAME

ADDRESS

POSTAL CODE

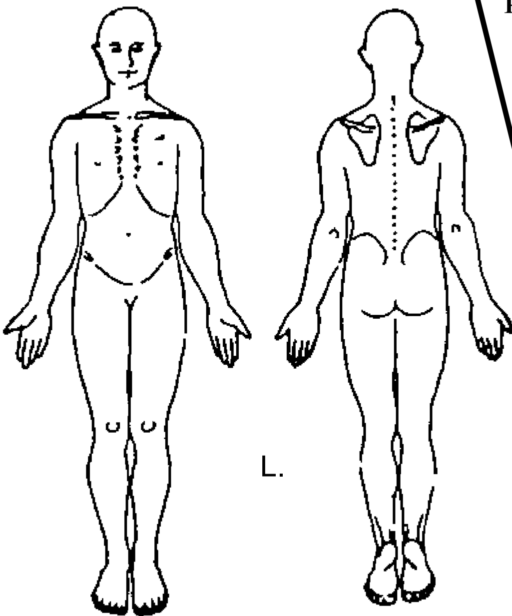
TODAY'S DATE | **BIRTH DATE**

OCCUPATION | **HOME PHONE** | **WORK PHONE**

HOW WERE YOU REFERRED TO US?

EMAIL ADDRESS*:____
***Your email address is kept and used for private contact purposes only.**

INDICATE PROBLEM AREAS:



WELCOME

Please briefly explain the nature of your present condition eg: locations and nature of discomforts, duration, activities affected, etc ... Indicate problem areas on the diagram located to the left. THANK YOU

24 hours notice must be given for a cancellation of appointments or a charge will apply. I understand the above statement.
In the event of unhonoured MSP/ICBC claims, payment is the responsibility of the patients.

Initial here: X____________

OFFICE USE ONLY
MSP / ICBC / WCB / PVT.
PHN
NAME
BIRTHDATE M M D D Y Y
MD
MVA DATE
CLAIM #
ADJUSTOR
LAWYER

PLEASE CHECK IF ANY OF THE FOLLOWING APPLY TO YOU:

HEART CONDITION	☐	INSOMNIA	☐
CIRCULATORY CONDITION	☐	FRACTURE	☐
HIGH/LOW BLOOD PRESSURE	☐	FAINTING	☐
KIDNEY CONDITION	☐	DIABETES	☐
SPINAL INJURY	☐	PREGNANT	☐
RESPIRATORY CONDITION	☐	CONTACT LENSES	☐
INFECTIOUS CONDITION	☐	STROKE	☐
NEUROLOGICAL CONDITION	☐	CANCER	☐
HEAD INJURY	☐	ALLERGIES	☐
SEIZURES	☐	MEDICATIONS____________________	
HEADACHE	☐	____________________	
JAW PAIN	☐	OTHER____________________	