aloe massage therapy

Name _____ Address _____

Birth date(M/D/Y) _____ _____

Phone (home) _____ ICBC Claim? Y or N

(Work) _____ Family doctor _____

(Cell) _____ Occupation _____

Email _____ How did you hear about us?_____

Please check all of the following that apply

- ❑ Heart attack
- ❑ High/low blood pressure
- ❑ Other heart condition
- ❑ Varicose veins
- ❑ Bruise easily
- ❑ Other circulatory conditions
- ❑ Diabetes
- ❑ Kidney disease
- ❑ Pregnancy
- ❑ Cancer
- ❑ Headaches/Migraines
- ❑ Dizziness/Fainting
- ❑ Nausea
- ❑ Head injury
- ❑ Spinal injury
- ❑ Epilepsy
- ❑ Other neurological conditions
- ❑ Asthma
- ❑ Chronic sinusitis
- ❑ Other respiratory conditions
- ❑ Digestive condition (IBS/Colitis)
- ❑ Skin condition
- ❑ Joint dislocation (present or past)
- ❑ Bone fracture (present or past)
- ❑ Arthritis
- ❑ Osteoporosis
- ❑ Rods/Pins/Plates
- ❑ Hepatitis
- ❑ HIV
- ❑ Other contagious conditions

Medications you presently take_____

Known allergies _____

Major accidents, illnesses or surgeries _____

_____

Activities, sports or hobbies _____

Current Condition

Please describe your current condition and symptoms

_____

_____

_____

_____

How long have you had this condition? _____

_____

_____

How did it start? _____

_____

_____

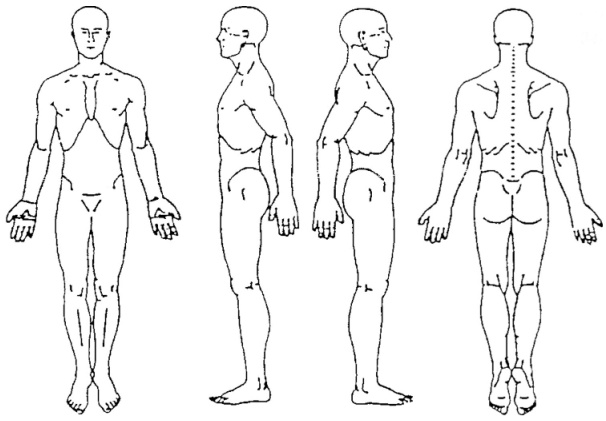
What aggravates it? _____

_____

What relieves it? _____

_____

Indicate the location of your symptoms.



Please note: Your appointment time has been reserved for you. In courtesy of your therapist & fellow patients, we ask that you provide us with 24 hours notice of cancellation, or a cancellation fee will be charged. Email reminders for appointments are a courtesy, if you don't receive one; it is still your responsibility to arrive on time for the appointment. Payment for all treatments, whether private or insured, is ultimately the responsibility of the patient.

I authorize the clinic and its associated RMTs to collect my personal medical information as documented above in order to contact me, and give permission for the clinic to leave messages regarding appointments at any of the contact numbers/email addresses I have provided. In addition, I authorize the clinic and its associated RMTs to communicate with my referring MD as deemed necessary for my beneficial treatment. I also understand that my personal and medical information is confidential and will only be disclosed to third parties with my permission.

Signature _____ Date: _____

For Office Use Only:

- ❑ Massage Therapy — Date of last visit (approx) _____
- ❑ Acupuncture — " _____
- ❑ Physiotherapy — " _____
- ❑ Athletic therapy — " _____
- ❑ Naturopath — " _____
- ❑ Chiropractor — " _____
- ❑ Other _____ — " _____

Quality of sleep	1	2	3	4	5	Hours of sleep per night (approx) _____
Energy Level	1	2	3	4	5	
Stress Level	1	2	3	4	5	
Exercise Habits	1	2	3	4	5	Number of times you exercise per week _____