

Aloe Massage Therapy

Name _____

Address _____

Birth date (m/d/y) _____

Phone (Home) _____

Postal Code _____

(Work) _____

ICBC Claim? Y or N

(Cell) _____

How did you hear about us? _____

Family Doctor _____

Occupation _____

Email _____

Please check all of the following that apply to you and indicate whether past or current (P = Past C = Current)

- | | | |
|---|--|--|
| <input type="checkbox"/> Heart Attack | <input type="checkbox"/> Headaches/Migraines | <input type="checkbox"/> Digestive condition |
| <input type="checkbox"/> High/Low Blood Pressure | <input type="checkbox"/> Dizziness/Fainting | <input type="checkbox"/> Skin condition |
| <input type="checkbox"/> Other Heart Conditions | <input type="checkbox"/> Nausea | <input type="checkbox"/> Joint dislocation |
| <input type="checkbox"/> Varicose Veins | <input type="checkbox"/> Head Injury | <input type="checkbox"/> Bone Fracture |
| <input type="checkbox"/> Bruise Easily | <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Arthritis |
| <input type="checkbox"/> Other Circulatory Conditions | <input type="checkbox"/> Other Neurological Conditions | <input type="checkbox"/> Osteoporosis |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Asthma | <input type="checkbox"/> Rods/pins/plates |
| <input type="checkbox"/> Kidney Disease | <input type="checkbox"/> Chronic Sinusitis | <input type="checkbox"/> Hepatitis |
| <input type="checkbox"/> Pregnancy | <input type="checkbox"/> Other respiratory conditions | <input type="checkbox"/> HIV |
| | <input type="checkbox"/> Cancer | <input type="checkbox"/> Other Contagious Conditions |

Please list any medications you presently take _____

Known allergies _____

Please list any major accidents, illness or surgeries _____

Please list any Activities, sports or hobbies _____

Other therapy/treatment (past or present, and does not need to be related to this visit)

- | | |
|---|-----------------------------------|
| <input type="checkbox"/> Massage Therapy | Date of last visit (approx) _____ |
| <input type="checkbox"/> Acupuncture | “ _____ |
| <input type="checkbox"/> Physiotherapy | “ _____ |
| <input type="checkbox"/> Athletic therapy | “ _____ |
| <input type="checkbox"/> Naturopath | “ _____ |
| <input type="checkbox"/> Chiropractor | “ _____ |
| <input type="checkbox"/> Other _____ | “ _____ |

Please CIRCLE the answer closest to how you PRESENTLY feel (1 = poor, 5 = excellent)

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	Number of times you exercise per week _____
Exercise Habits	1 2 3 4 5	

Current Condition

Please describe your current condition and symptoms

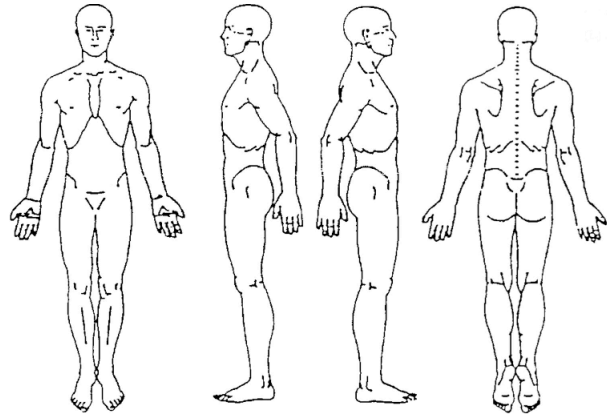
How long have you had this condition? _____

How did it start? _____

What aggravates it? _____

What relieves it? _____

Using the diagram below, 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. Please note, 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 and 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 above. 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: _____