West Side
MASSAGE THERAPY
Guiding Your Wellness Journey

CONFIDENTIAL CLIENT HISTORY

NAME_____ BIRTH DATE_____

ADDRESS _____ CITY/TOWN_____

POSTAL CODE_____E-MAIL_____

PHONE – (H) _____(W) _____(cell) _____

EMPLOYER _____OCCUPATION_____

Emergency Contact Name_____Phone #_____Relationship_____

Whom may we thank for referring you to our clinic?_____

MEDICAL HISTORY

Is this a claim with SGI ( ) or WCB ( ) or Veteran's Affairs ( ) Claim #_____
Name of injury worker _____ Phone # _____
Date of Injury _____

PHYSICIAN _____PHONE OR ADDRESS_____
Last physical or visit? _____

Are you presently taking any prescription or non-prescription medication, supplements or natural remedies? Please list

NAME	REASON
_____	_____
_____	_____
_____	_____
_____	_____

Do you have any **Allergies?** _____

Are you receiving treatment from any of the following at the present time?
Physician ( ) Chiropractor ( ) Physiotherapist ( ) Naturopath ( ) Acupuncturist ( ) Massage Therapist ( )
Exercise Therapist ( ) Manual Osteopathic Therapist ( ) Other: _____

Exercise & physical activity: ( ) very 5-7 X/week ( ) moderate 3-4 X/ week ( ) light 1-2 X/week ( ) sporadic ( ) none
Work, do you routinely: ( )sit ( )stand ( ) light manual labour ( ) heavy labour ( )combination
Daily water consumption? ( ) light ( ) moderate ( ) heavy
Caffeine? ( ) light ( ) moderate ( ) heavy
How do you sleep? ( ) Well ( ) Variable ( ) Not Well
What is your diet like? ( ) Well Balanced ( ) Variable ( ) Needs Improvement
How are your energy levels? ( ) High Energy ( ) Moderate ( ) Low Energy
Type of activities or hobbies? _____

OVER>>>>>>

Please indicate Current conditions with a C and Previous with a P?

Cardiovascular:
( ) High/Low Blood Pressure
( ) Heart Disease/Conditions
( ) CHF or Heart Attack
( ) Phlebitis/Thrombosis
( ) Circulatory Conditions
( ) Varicose Veins
( ) Stroke/CVA
( ) Cold hands/feet
( ) Swelling in hands/feet
( ) Poor wound healing
( )Pacemaker or other devices

Soft Tissue/Joint/Nerve:
( ) Fibromyalgia
( ) Arthritis___RA___OA
( ) Herniated Disc(s) Level___
( ) Osteoporosis
( ) Fracture: Where_____
( ) Thoracic Outlet Syndrome
( ) Head Trauma/Concussion
( ) Whiplash/Car Accident
( ) Neck pain/Stiffness/Injury/Numbness
( ) Shoulder Pain/Stiffness/Injury
( ) Arm Pain/Weakness/Numbness
( ) Back Pain/Stiffness/Injury
( ) Leg Pain/Weakness/Injury/Numbness
( ) Knee or Foot Pain/Injury
( ) Tendonitis/Tenosynovitis
( ) Bursitis or Dislocation
( ) Sport/Work Related Injury
( ) Carpel Tunnel Syndrome

Respiratory:
( ) Chronic Cough
( ) Shortness of Breath
( ) Respiratory Disease
( ) Bronchitis/Asthmas
( ) Sinus Infections Emphysema
( ) Smoke/Vape

Digestive:
( ) Constipation
( ) Nausea/Vomiting
( ) Ulcers/Blood in Stool
( ) Liver/Kidney Problems
( ) Rapid Weight Loss/Gain
( ) Appetite Changes
( ) Ulcerated Colitis/Crohn's/IBS

Head and Neck:
( ) Tension/Migraine Headaches
( ) Tinnitus (ringing in ears)
( ) Tooth/Jaw/Ear Pain
( ) Vision Problems/Loss
( ) Hearing Loss
( ) Dizziness/Vertigo/Lightheaded
( ) Other:_____

Women:
( ) Painful Menstruation
( ) Pelvic Inflammatory Disorder
( ) Hysterectomy
( ) Birth Control
( ) C-section
( ) Pregnant – Due: _____

Skin:
( ) Bruise easily
( ) Rash/Open sores/Warts
( ) Sensitivity/skin allergies:_____
( )Contagious skin disease
( ) Shingles

Urinary:
( )Chronic Infections
( ) Blood in Urine

Endocrine:
( ) Thyroid Problems
Type:_____

Infections:
( ) Hepatitis
( ) Tuberculosis
( ) HIV

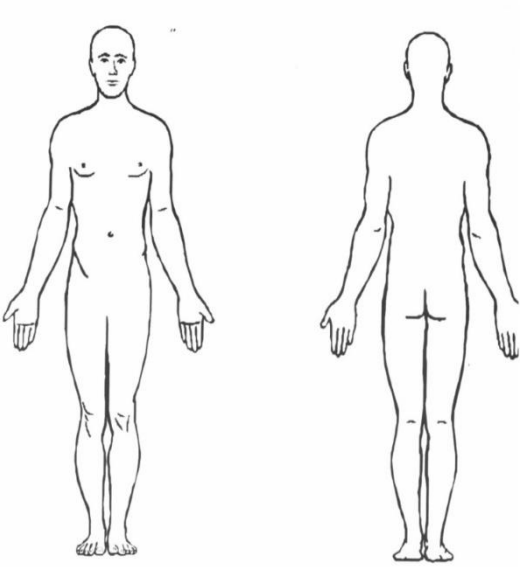
Other Conditions:
( ) Loss of Sensation
( ) Diabetes – Onset/Type:_____
( ) Epilepsy
( ) Insomnia
( ) Depression/Anxiety
( ) Multiple Sclerosis
( ) Cancer – Onset/Type:_____
( ) Substance Dependency
( ) Other: _____

REASON FOR VISIT Therapy?_____Relaxation?_____
Please describe your present complaint:
_____
_____
_____
_____
_____
_____

Initial onset of pain?_____
Is the pain ( )local ( )radiating ( ) throbbing ( ) dull
( ) stabbing ( ) pins & needles ( ) numbness ( ) burning
( ) intermittent ( ) constant
Is the pain ( ) less ( ) worse later in the day or
( ) less ( ) worse on waking?

Have you had any surgeries in the past? Y/N
Please explain _____
_____
Have you ever had any fractures? Do you have any pins,
plates, or joint replacements? or any other notes of caution_____

Shade in areas of concern on the diagram:



_____ _____ _____
Print Name Signature of patient Date