MASSAGE CONFIDENTAL CASE HISTORY

Name:_____ Date:_____

Address:_____City/Province:_____

Postal Code:_____ Home Phone:_____ Cell Phone:_____

Birth Date:_____ Height:_____ Weight:_____

How did you find out about out clinic?_____

Reason for consulting the clinic?_____

Occupation:_____

Work name & address:_____

Physician:_____Chiropractor:_____

If the reason for today's treatment is a motor vehicle accident, please state:

SGI Adjusters name:_____

Claim Number: _____

Date of Accident: _____

Describe Accident:_____

Type of injury:_____

If the reason for today's treatment is a work related injury please state:

WCB Adjusters Name:_____

Claim Number: _____

Date of Accident: _____

Describe Accident:_____

Have you been to a massage therapist before? YES ( ) NO ( )

Are you under any medical supervision presently? YES ( ) NO ( )

If yes, for what condition(s)?_____

Are you currently taking any medications (including pain killers and/or birth control)?

_____

_____

Have you had surgery? YES ( ) NO ( )

If yes, please list: _____

Do you have any allergies/sensitivities? YES ( ) NO ( )

If yes, please list: _____

Do you have frequent headaches? YES ( ) NO ( )

Do you have any heart conditions? YES ( ) NO ( )

Do you have high or low blood pressure? YES ( ) NO ( )

Do you have varicose veins? YES ( ) NO ( )

Have you ever had cancer? YES ( ) NO ( )

Do you have arthritis? YES ( ) NO ( )

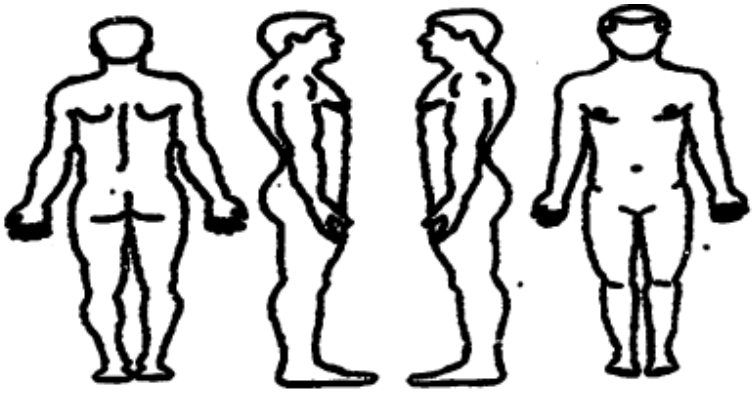
Do you have chronic diarrhea? YES ( ) NO ( )

Are you pregnant? YES ( ) NO ( ) If yes, which trimester?_____

Reason for treatment today? _____

PLEASE INDICATE, WITH THE KEY BELOW,YOUR PROBLEM AREAS ON THE DIAGRAM

KEY: A= ACHE B=BURNING N=NUMBNESS P=PINS AND NEEDLES S=STABBING



I hereby consent and understand that the massage therapist does not diagnose illness, disease or any physical ailment. The massage therapist does not prescribe other medical treatments or perform spinal manipulations.

Massage therapy is not a substitute for medical examinations or diagnosis and it is recommended that I see a physician for any physical ailment.

I have stated all my known conditions and if anything should change or if I cannot make my scheduled appointment, I will kindly give 24 hours notice. If I fail to give 24 hours notice I agree to pay the full amount of my treatment

_____ _____

Signature Date