Today's Date (Date, Month, Year): ______________________________

Practitioner (Please select):

- ☐ Cheryl Cooper, ND
- ☐ Erin Whyte, RMT
- ☐ Heather Resvick, RHN, ROHP
- ☐
- ☐ Elizabeth Brothers, ND
- ☐ Dr Aloke De, MBBS
- ☐

Name: ______________________________

Address: ______________________________

City: ____________________ Province: ____________ Postal Code: ____________

Home Phone #: ____________________

Mobile Phone #: ____________________

Office Phone #: ____________________

Preferred contact method? Home #: _____ Mobile #: _____ Work #: _____ Email: _____

Email Address: ______________________________

Sex: M _____ F _____ Birthdate (Date, Month, Year): _____ ____________ _______

How did you find out about us?

- ☐ Vitallife web site
- ☐ Internet Search (ie Google)
- ☐ Sign/Walking By
- ☐ **Advertisement**
- ☐ Other Internet site:
- ☐ Other health care provider:
- ☐ Family/friend:
- ☐ **Other:** ______________________________

Office Use

- ☐ Status to Active
- ☐ Practitioner Selected
- ☐ Cancellation Policy in Notes
- ☐ Referral Method

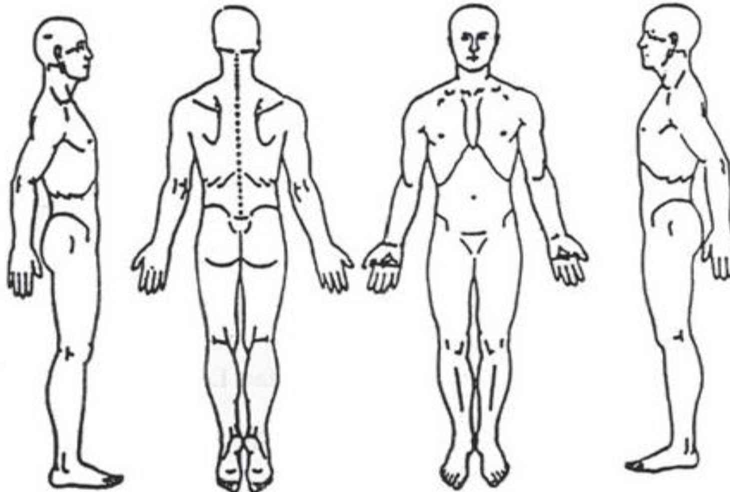
Emergency Contact
Name ___________________________________
Address _________________________________
____
Phone # _________________________________

Physician's Contact
Name _____________________________________
Address ___________________________________
____
Phone # ___________________________________

How is your general state of health? _____________
Activities (type and frequency): ____
Sleep: 8 + hours/night ☐ 5-8 ☐ less than 5 ☐ Soundly ☐ Interrupted ☐
Primary sleep position: ______________________ Left or right handed:_____________________
Have you received Massage Therapy treatments before?: Yes___ No___ How long ago?: ___________

Are you here for: Wellness ☐ Physical complaint ☐
What is your primary goal and focus of today's treatment? ______________________________________
____

Please circle the location of any muscle or joint discomfort:



Are you experiencing:
Fatigue ☐
Numbness ☐
Tingling ☐
Headaches ☐
Decreased flexibility ☐

Is your pain:
Dull ☐
Sharp ☐
Burning ☐
Other: __________________

Are you currently involved in treatment with other health care practitioners? If so, what are they?
____
Please list current medications and the conditions they are treating:
____
____
____

Please list the nature of any motor vehicle accidents, injuries, or surgical procedures:
Date: _________ Reason: ____
Date: _________ Reason: ____
Date: _________ Reason: ____
Date: _________ Reason: ____

Do you have any disc degeneration? Yes ___ No ___ Unknown ___
Do you have any internal pins, wires or artificial joints? Yes ___ No ___
Please list any allergies: ____

The following conditions could modify the treatment that you receive, please read them carefully and check off any that apply (present or past). If something isn't listed please add it in "Other conditions".

Head/Neck
Migraines ☐ Headaches ☐
Impaired or loss of vision ☐
Impaired or loss of hearing ☐
Numbness/tingling in hands ☐

Infectious Conditions
Skin conditions ☐
Respiratory condition ☐
Hepatitis ☐
HIV/AIDS ☐

Other Conditions
Diabetes ☐ Onset: ________
Epilepsy ☐
Osteoporosis ☐
Cancer ☐
Digestive condition ☐
Arthritis ☐ Type: __________

Cardiovascular Conditions
High blood pressure ☐
Low blood pressure ☐
Heart disease ☐
Heart attack ☐
Stroke/CVA ☐
Presence of pacemaker ☐
Varicose veins ☐
Family history of any of the above ☐

Respiratory Conditions
Emphysema ☐
Bronchitis ☐
Asthma ☐
Chronic cough ☐
Shortness of breath ☐
Family history of respiratory difficulties ☐

Women only:
Gynaecological conditions ☐
Are you pregnant? Y ☐ N ☐
Due date: _______________

Please list any other concerns: ____
____
____

Privacy and Confidential Health History

I understand that the information provided on my health history and any information discussed during my assessment or treatment is strictly confidential. My written permission is required in order for any other health practitioner and my massage therapist to discuss or exchange any of my personal information.
Initials: ___________

The contents of this medical health history are confidential. It will assist in assessing and formulating a treatment plan to meet your goals as set out in your first appointment. If any of this information is to be released, you will be asked to provide written authorization to do so. At any point, *if your health status changes please inform your therapist* as it may alter your treatment plan.

Please sign below to confirm that you had read and understand the above and that you give your consent to treatment.

Signature_____________________________________ **Date** ___________________________

Health History Review (one year) Initial: _______ Date: ________
Health History Review (one year) Initial: _______ Date: ________
Health History Review (one year) Initial: _______ Date: ________