West Side
MASSAGE THERAPY
Guiding Your Wellness Journey

CONFIDENTIAL PATIENT HISTORY

NAME_____ BIRTH DATE_____

ADDRESS_____ CITY/TOWN_____

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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?** _____

Have you ever been diagnosed or treated for any of the following?

( ) High/Low Blood Pressure	( ) Diabetes	( ) Rheumatoid Arthritis	( ) TMJ
( ) Heart Disease/Conditions	( ) Kidney Disease	( ) Osteoporosis	( ) Whiplash
( ) Phlebitis/Thrombosis	( ) Liver Disease	( ) Skin Infections	( ) Carpal tunnel
( ) Circulatory Conditions	( ) Crohn"s Disease	( ) Frequent cough	( ) Shingles
( ) Varicose Veins	( ) Epilepsy	( ) Menstrual Cramps	( ) HIV
( ) Stroke	( ) Cancer	( ) Pelvic Inflam. Disorder	( ) MS
( ) Headaches/Dizziness	( ) Thyroid Problems	( ) Urinary	
( ) Respiratory Disease	( ) Anxiety/Depression	( ) Substance Dependent	( ) other_____

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

Are you pregnant? Y / N If yes, when is your due date?_____

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