



Associate Massage Therapy Clinic and Laser Therapy Center

#115 – 5301 – 43rd Street
 Red Deer, Alberta
 T4N 1C8
 (in The Old Brew Plaza)

Hours of Operation

Monday to Friday – 9 am to 9 pm
 Saturday – 9 am to 5 pm
 Ph. 403.340.0820

CONFIDENTIAL CLIENT INFORMATION

Name _____ Phone (home) _____
 Sex M F Birthday _____ Phone (work) _____
 Address _____ Phone (cell) _____
 City _____ Postal Code _____
 Occupation _____ Employer _____
 Height _____ Weight _____ E-mail _____

Medical History (list present/previous illnesses, conditions, accidents, surgeries, fractured bones)

 What sporting/exercise activities are you involved in: _____
 Please list current medications: _____
 Medical Doctor: _____ Chiropractor: _____
 Physiotherapist: _____ Other Health Professionals: _____
 Previous Massage Experience: Y _____ N _____ Comments: _____

Purpose of this Appointment (Major Complaint): _____

 When did these symptoms appear: _____
 Have you ever had same or similar condition? _____ If yes, when and describe: _____
 How is this condition interfering with your daily routine? _____
 Is it progressively getting worse? Y _____ N _____ Constant? _____ Comes & Goes? _____
 What makes it worse? _____
 What makes it better? _____
 Other complaints: _____



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Confidential Health History

In order to protect yourself, your therapist, and others, honest disclosure is essential.

Head/ Neck:

- headaches
- tension
- migraine
- whiplash
- TMJ
- vision problems
- contact lenses
- earaches
- hearing problems
- sinus problems

Respiratory:

- rib injuries
- breathing difficulties

Cardiovascular:

- high blood pressure
- low blood pressure
- phlebitis
- dizziness
- heart disease
- varicose veins
- blood clots
- circulation problems

Skin:

- allergies
- bruise easily
- other: _____

Muscles/ Joints:

- pain _____
- sprains
- strains
- spasms
- tears
- numbness/ tingling
- bursitis
- tendonitis
- arthritis _____

Digestive:

- constipation
- diarrhea
- gas
- digestion problems
- _____
- other _____

Skeletal:

- broken bones: _____
- _____
- osteoporosis
- date of diagnosis _____
- spinal condition
- _____

Other:

- kidney/ bladder problems
- diabetes – type _____
- seizures _____
- herpes
- hepatitis
- HIV
- other contagious conditions

Women:

- menstruation problems
- _____
- pregnant?
- due date _____
- number of children _____
- menopause problems
- _____

Cancellation Policy

Your appointment time is reserved especially for you. Any cancellations or rescheduling must be done with a minimum of six (6) business hours, or you will be charged the cost of your appointment. Without adequate notice, you are preventing someone else from receiving the help that they may need. Thank you for your co-operation and understanding.

I understand that the information I have given on this form will be confidential and will be used for no other purpose than the therapist's records, and/or for the mailing of timely reminders. The contents of this form and related documents are the property of the clinic. I also verify that the above information is correct and complete.

Signature: _____ Date: _____