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:** _____