LiveWell4Life inc.
fitness - nutrition - therapy

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Registered Massage Therapy Health History

Name:					
Address:		**City:**		**Province:**	**Postal Code:**
Home Phone:	**Work Phone:**	**Cell Phone:**	**Email:**		
Date of Birth:		**Sex:** □**M** □**F** **Other:** _____	**Occupation:**		
Doctor's Name:		**Doctor's Address:**		**Doctor's Phone:**	
May I contact your Doctor? □**Yes** □**No**		**How did you find out about LiveWell4Life?**			

Have you received Registered Massage Therapy before? □**Yes** □**No**
If yes, when was your last treatment?

What results do you wish to see from your Massage Therapy treatment?

Are there any areas you would prefer not to receive massage therapy treatment on? □**Yes** □**No**
If yes, please explain:

Are you currently being treated by another healthcare professional for a specific condition? □**Yes** □**No**
If yes, please explain:

Have you been treated in the past by another healthcare professional for a specific condition? □**Yes** □**No**
If yes, please explain:

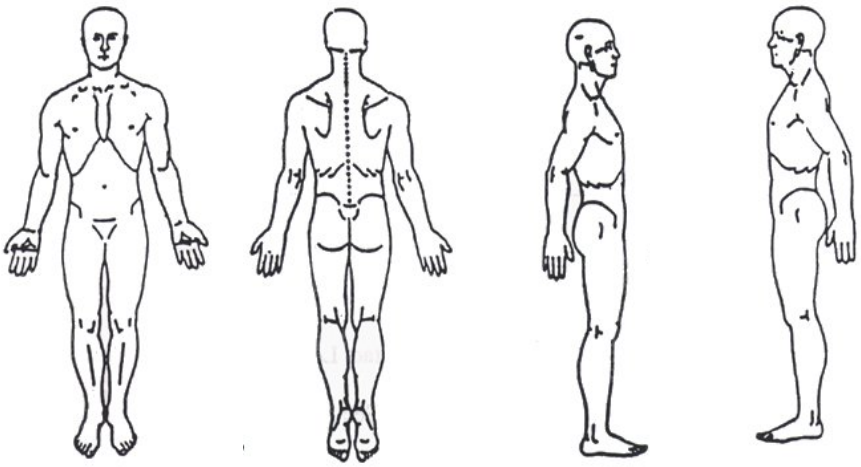
Symptom Diagram

In the diagrams below, please mark the areas on your body that you feel best represent the pain(s) or sensation(s) you are experiencing. Please include all areas. Use the symbols provided below.

Numbness: = = = = = =
Burning: x x x x x x

Dull & Aching: △△△△△△
Pins & Needles: o o o o o o

Stabbing & Sharp ~ ~ ~ ~ ~ ~ Stiff & Tight: z z z z z z



front back right left

Please see the other side of this form and check all areas that pertain to you.

Health Status Survey

Please X the box for any conditions or symptoms **presently** causing you problems.
Please check (✓) the box for those conditions or symptoms **that you have had in the past.**

Muscles/Joints/Nerves

□ Headaches (migraine/tension/other)
□ Neck pain/injury/whiplash
□ Arm pain/weakness/tingling
□ Tooth/jaw/ear pain/TMJ
□ Back Pain/injury
□ Sciatica/hip pain
□ Scoliosis/spinal curvature
□ Leg pain/weakness/tingling
□ Poor posture
□ Sports Injury _____
□ Work Injury _____
□ Vision Problems/dizziness
□ Head Trauma/concussion
□ Loss of Co-ordination
□ Sleep Problems/disorder
□ Muscle/nerve disease
□ Strain/sprain
□ Tendonitis/bursitis
□ Fractures/bone disease
□ Degenerating disc
□ Osteo/Rheumatoid arthritis
□ Osteoporosis
□ Fibromyalgia
□ Other: _____

Heart/Circulation

□ High Blood Pressure
□ Low Blood Pressure
□ Heart Attack/disease
□ Stroke
□ Chest Pain/angina
□ Blood Clots
□ Pace Maker/similar device
□ Varicose veins/phlebitis
□ Poor healing/bruise easily
□ Poor circulation
□ Cold hands and feet
□ Lightheaded/fatigue
□ Swelling
□ Diabetes: Type _____
□ Other: _____

Digestion

□ Constipation/Diarrhea
□ Nausea
□ Rapid Weight Loss
□ Ulcers/Crohn's/colitis
□ Liver/gallbladder issues
□ Other: _____

Skin

□ Open sore/cuts/warts
□ Rashes/athlete's foot
□ Allergies (skin irritation)
□ Any topical medication _____
□ Other: (infectious) _____

Genitourinary

□ Painful urination
□ Unusual urine colour/odour
□ Bladder/kidney infection
□ Prostate problems
□ Incontinence
□ Other: _____

Lungs/Respiration

□ Asthma/bronchitis/emphysema
□ Chronic smoking/cough
□ Frequent colds
□ Seasonal allergies/sinus problems
□ Shortness of breath
□ Sinus problems
□ Smoking/vaping
□ Other: _____

Other Conditions

□ Hepatitis: Type _____
□ HIV Infection
□ Multiple Sclerosis
□ Cancer
□ Epilepsy
□ Tuberculosis
□ Drug/alcohol addiction
□ Anxiety
□ Other: _____

FEMALE ONLY:
Are you Pregnant? YES□. NO□
If yes, how many weeks? _____
□ Menstrual problems
□ Menopause
# of Children _____

Rate your general health:
□ Poor. □ Good. □ Excellent

1. Have you ever had any fractures? If yes, where? □ Yes □ No Explain: _____
2. Have you ever been in a car accident? If yes, when? □ Yes □ No Explain: _____
3. Have you ever been hospitalized? When/why? □ Yes □ No Explain: _____
4. Do you have any surgical plates, pins, wires, artificial joints, or special equipment? □ Yes □ No. Explain: _____
5. Please list any prominent diseases in your immediate family (ie. Heart Disease, Cancer, Diabetes, Etc)

_____

Are you presently taking **medication** (include over the counter drugs): (if more than 3 we can photocopy your list)

Name: _____ Condition: _____ Last Taken: _____
Name: _____ Condition: _____ Last Taken: _____
Name: _____ Condition: _____ Last Taken: _____

□ I understand the information given on this form is absolutely confidential, and will only be released to other health care professionals or legal representatives with my written consent. I understand that LiveWell4Life Inc. will maintain my files.
□ I understand that if for any reason I am unable to keep my scheduled appointment I will notify LiveWell4Life Inc. by phone at least 24 hours ahead of scheduled time. I understand that if I do not cancel appointment 24 hours ahead of time that I will be responsible for covering fees of the set appointment.
□ I have read and fully understood the above statements.

Signature: _____

Date: _____

THERAPIST USE ONLY:
CASE HISTORY ANNUAL FOLLOW-UP
Initial & Date: _____
Initial & Date: _____
Initial & Date: _____
Initial & Date: _____
Initial & Date: _____
Initial & Date: _____
Initial & Date: _____
Initial & Date: _____