



Client Health History

Name: _____ Today's Date: _____
Address: _____ City: _____
Postal Code: _____ Phone: _____
Email: _____ Date of Birth: _____
Would you like to sign up for my FREE client e-newsletter and receive my free report:
'21 ways to break the chronic pain cycle'? Yes No
Occupation & related duties: _____
BC Medical Care Card number (PHN): _____
Doctor: _____ Phone: _____ May I contact? Yes No
Emergency contact person: _____ Phone: _____
Do you presently have an insurance claim with **ICBC**? Yes No OR a **WorkSafe BC** claim? Yes No
If yes, please indicate claim number: _____ and case worker _____

Before I ask you about your discomfort, tell me, what in your life brings you Joy?

What are your goals in receiving massage therapy today? (please check all that apply)

- relaxation / stress reduction injury rehabilitation chronic pain relief sports training
 maintain wellness other _____

Please CIRCLE the answer closest to how you PRESENTLY feel: (1 = poor, 5 = excellent)

Quality of sleep	1	2	3	4	5
Energy level	1	2	3	4	5
Exercise habits	1	2	3	4	5
Stress management	1	2	3	4	5
Eating habits	1	2	3	4	5

Have there been any significant changes in your life in the past 6 months to 1 year? If yes, please describe:

Are you presently happy with how your body is serving you? Yes No

If not, what would you like to improve? _____



Please mark an "X" beside any conditions which are currently disrupting your life, or mark a "P" if it was an issue in your past:

<p>HEAD / NECK:</p> <p><input type="checkbox"/> headaches <input type="checkbox"/> sinus infections</p> <p><input type="checkbox"/> vision problems <input type="checkbox"/> neck pain</p> <p><input type="checkbox"/> ringing in ears <input type="checkbox"/> jaw pain</p> <p><input type="checkbox"/> hearing loss</p> <p>Other: _____</p>	<p>CARDIOVASCULAR:</p> <p><input type="checkbox"/> high blood pressure <input type="checkbox"/> chest pain</p> <p><input type="checkbox"/> low blood pressure <input type="checkbox"/> stroke</p> <p><input type="checkbox"/> poor circulation <input type="checkbox"/> phlebitis</p> <p><input type="checkbox"/> heart disease <input type="checkbox"/> varicose veins</p> <p>Other: _____</p>
<p>MUSCLES / JOINTS:</p> <p><input type="checkbox"/> disc problems</p> <p><input type="checkbox"/> bursitis</p> <p><input type="checkbox"/> arthritis: where? _____</p> <p><input type="checkbox"/> tendonitis: where? _____</p> <p><input type="checkbox"/> dislocation: where? _____</p> <p><input type="checkbox"/> fracture: where? _____</p> <p><input type="checkbox"/> osteoporosis</p> <p>DIGESTIVE PROBLEMS:</p> <p><input type="checkbox"/> please describe: _____</p> <p>_____</p>	<p>RESPIRATORY:</p> <p><input type="checkbox"/> asthma <input type="checkbox"/> chest pain</p> <p><input type="checkbox"/> bronchitis <input type="checkbox"/> emphysema</p> <p><input type="checkbox"/> hay fever <input type="checkbox"/> pneumonia</p> <p>Other: _____</p> <p>SKIN:</p> <p><input type="checkbox"/> sensitive skin <input type="checkbox"/> warts</p> <p><input type="checkbox"/> bruise easily <input type="checkbox"/> athlete's foot</p> <p><input type="checkbox"/> eczema <input type="checkbox"/> rash / hives</p> <p><input type="checkbox"/> psoriasis <input type="checkbox"/> other _____</p>
<p>NERVOUS/ENDOCRINE:</p> <p><input type="checkbox"/> dizziness or fainting</p> <p><input type="checkbox"/> numbness/tingling</p> <p><input type="checkbox"/> anxiety</p> <p><input type="checkbox"/> sleep disorders</p> <p><input type="checkbox"/> depression</p> <p><input type="checkbox"/> muscle jerking</p> <p><input type="checkbox"/> seizures</p> <p><input type="checkbox"/> chronic fatigue syndrome</p> <p><input type="checkbox"/> thyroid dysfunction</p> <p><input type="checkbox"/> fibromyalgia</p> <p>Other: _____</p>	<p>REPRODUCTIVE:</p> <p><input type="checkbox"/> painful or irregular menstruation</p> <p><input type="checkbox"/> menopause</p> <p><input type="checkbox"/> pregnant?</p> <p>If current, how many weeks? _____</p> <p>If past, how many pregnancies? _____</p> <p><input type="checkbox"/> prostate problems</p> <p>Other: _____</p> <p>URINARY:</p> <p><input type="checkbox"/> bladder infection</p> <p><input type="checkbox"/> kidney stones</p> <p><input type="checkbox"/> other _____</p>

Please indicate any other major illnesses, injuries or surgeries that you have experienced: _____

Current medications & supplements: _____

PAIN DIAGRAM

Please mark an "X" or circle over the areas you experience pain or discomfort.

The diagram consists of three human figures: a front view on the left, a side view in the middle, and a back view on the right. Each figure has a dotted line representing the spine. The front view shows the chest, abdomen, and legs. The side view shows the profile of the body. The back view shows the spine, shoulders, and buttocks. There are small tick marks on the arms and legs of each figure, indicating potential areas for marking pain.

IF CHRONIC PAIN IS YOUR CONCERN, PLEASE COMPLETE THE FOLLOWING:

On the line provided, please mark where your "pain status" is today:

|-----|
 No pain Most severe pain

On the line provided, please mark where your "pain status" was when it was at its most severe:

|-----|
 No pain Most severe pain

Please read and sign for consent to massage therapy by Sonja Rawlings, RMT, RA, EOT.

I confirm that the information I have provided is true and complete to the best of my knowledge. I understand that the above information and the details of my massage therapy treatments are confidential and will not be released without my written consent, unless otherwise required by law. I consent to receive integrative massage therapy from Sonja Rawlings, RMT, RA, EOT. I understand that I am responsible for payment upon receipt of service and that in order to receive partial or complete reimbursement from a 3rd party insurance provider, I must submit my massage therapy receipts to the provider directly. I agree to provide a minimum of 24 hours notice when cancelling an appointment or 50% of charges will apply.

Client Signature

Today's Date