KAWARTHA THERAPEUTIC CENTRE

Samantha Sheehan
Registered Massage Therapist

265 Kent St. West, Unit 7, Lindsay, ON, K9V 2Z3
Tel: (705) 878-0463, Fax: (705) 878-0465

CONFIDENTIAL CLIENT INFORMATION FORM

Please take a few moments to complete this form as accurately as possible. If you need help with the form, please do not hesitate to ask our receptionists.

Name: _____ **Date:** _____
Address: _____**City:** _____**Postal Code:**_____
Home Tel: ( ) _____ **Cell Tel: ( )** _____**Work Tel:** _____
Date of Birth (D/M/Y): _____ **Age:** _____ **Gender:** ☐ **male** ☐ **female**
E-mail address: _____ **(100 % confidential - for appointment reminders/clinic newsletter)**
Occupation: _____**Employer:** _____
Extended Health Care Company: _____
Medical Doctor's name: _____
Approximate date of last medical appointment: _____**Reason for visit:** _____
How did you hear about our office? ☐ **A friend: if so, who?**_____
☐ **Medical Doctor** ☐ **Sign** ☐ **Ad** ☐ **Website** ☐ **Other:** _____
Have you ever been to a massage therapist before? ☐ **No** ☐ **Yes, if Yes, reason for visit:**_____

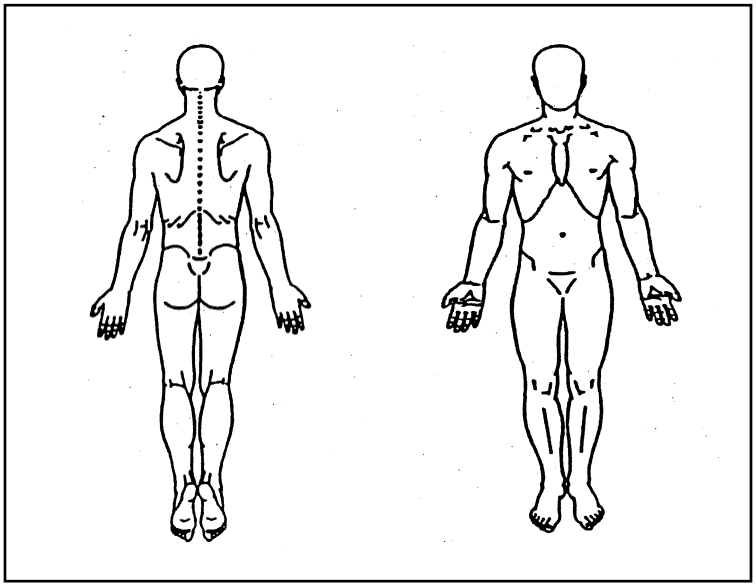
Why are you seeking massage therapy?_____
_____

If applicable, please describe your injury/painful condition, including what happened / how long ago / location of pain / aggravating and relieving factors and any other pertinent details:
_____
_____
_____

Characteristics of the pain/discomfort:

Using the key below, mark the areas of your body where you feel the described sensations. Use the appropriate symbols. Circle the area if you are unable to describe the sensation. Also mark areas of shooting or radiating symptoms. Include all affected areas:

XXX = Sharp Pain
TTT = Tense/Tight
BBB = Burning
AAA = Ache
+++ = Pins& Needles
///= Numbness
->->-> = Radiates
OOO = Other (describe)



Do you have any other (secondary) complaints? Please Describe: _____

_____

GENERAL HEALTH

Compared to 5 years ago, would you say your overall health is: □ better □ staying the same □ worse
Overall Stress Levels: □ high □ med-high □ medium □ med-low □ low
Medications you currently take: □ Painkillers □ Muscle Relaxants □ Anti-inflammatory □ Heart Meds □ Insulin
□ For Indigestion □For Depression □ For Anxiety □ For Asthma □ Blood Pressure □ HRT □ Other _____
Do you suffer from any other health conditions? □ No □ Yes (please list) _____

_____

PAST HEALTH HISTORY:

Please describe any hospitalizations or surgical operations and state the approximate dates: _____

_____

Please describe any previous traumas (accidents, sports injuries, work injuries, etc) and approximate dates: _____

_____

_____

The follow is a list of conditions, which may seem unrelated to your current complaint. However, we would like to assess your full health picture, and some of these conditions can also be affected by your overall courses of care. Please check the appropriate box for any of the following symptoms which you have now or have experienced previously. **C= currently P= previously**

C P
□ □ Diabetes
□ □ Loss of consciousness
□ □ Blackouts/fainting
□ □ Convulsions
□ □ Dizziness
□ □ Headaches
□ □ Loss of sleep
□ □ Fever
□ □ Sweats
□ □ Clumsiness
□ □ Loss of balance
□ □ Numbness in arm/hand
□ □ Numbness in leg/foot
□ □ Depression
□ □ Fatigue
□ □ Anxiety
□ □ Forgetfulness
□ □ Allergies
□ □ Recent weight gain
□ □ Recent weight loss

SKIN
C P
□ □ Itching
□ □ Skin rash
□ □ Bruises easily
□ □ Psoriasis
□ □ Varicose veins

MUSCLE & JOINT
C P
□ □ Osteoporosis
□ □Arthritis
□ □ Bursitis
□ □ Swollen joints
□ □ Foot trouble
□ □ Hernia
□ □ Low back pain
□ □ Neck pain
□ □ Neck stiffness
□ □ Pain in the joints
□ □ Weakness
□ □ Jaw pain/TMJ

CARDIOVASCULAR
C P
□ □ Aneurysm
□ □ Angina
□ □ Bleeding disorder
□ □ High blood pressure
□ □ Pain over the heart
□ □ Stroke
□ □ Heart attack
□ □ Ankle swelling

EYES, EARS, NOSE& THROAT
C P
□ □ Wear glasses/contacts
□ □ Blurred/double vision
□ □ Eye pain
□ □ Deafness
□ □ Ear aches
□ □ Ringing or buzzing in ears
□ □ Sinus infections
□ □ Enlarged glands
□ □ Enlarged thyroid
□ □ Difficulty swallowing

GENITO-URINARY
C P
□ □ Bed wetting
□ □ Painful urination
□ □ Blood in urine
□ □ Frequent urination
□ □ Loss control urine
□ □ Kidney infection
□ □ Prostate trouble

LUNG&BREATHING
C P
□ □ Asthma
□ □ Difficulty breathing
□ □ Chest pain
□ □ Chronic cough
□ □ Wheezing
□ □ Spitting blood

GASTROINTESTINAL
C P
□ □ Poor appetite
□ □ Loss of weight
□ □ Indigestion
□ □ Nausea
□ □ Vomiting
□ □ Vomiting blood
□ □ Pain over stomach
□ □ Constipation
□ □ Diarrhea
□ □ Ulcer
□ □ Jaundice

REPRODUCTIVE SYSTEM
C P
□ □ Heavy/Painful menstruation
□ □ PMS
□ Pregnant, Due date_____
□ Trying to conceive
# of pregnancies _____
# of children _____
Menopausal? Y / N