

NEW WEST WELLNESS CENTRE

**#140- 815 First Street,
New Westminster, BC. V3L 2H7
604-777-1003**

MEDICAL HISTORY

NAME: _____ BIRTH DATE: _____

ADDRESS _____

CITY: _____ POSTAL CODE: _____

PHONE (H): _____ (C): _____

E-MAIL: _____ OCCUPATION: _____

HAVE YOU EVER HAD MASSAGE? _____ WHEN WAS THE LAST TIME? _____

ARE YOU SEEING ANY OF THE FOLLOWING: CHIROPRACTOR, PHYSIO, OTHER _____

FAMILY DOCTORS NAME AND #: _____

PLEASE LIST MEDICATIONS YOU TAKE: _____

PLEASE ANSWER THE FOLLOWING:

TOBACCO: PER DAY _____ CUPS OF WATER: _____

AVERAGE HOURS OF SLEEP: _____ QUALITY OF SLEEP: _____

REASON(S) FOR SEEKING MESSAGES THERAPY: _____

HOW LONG AGO DID CONDITION BEGIN? _____

HOW DID CONDITION BEGIN? _____

FEELS WORSE WHEN: _____

FEELS BETTER WHEN: _____

CONTINUED ----- PLEASE TURN OVER TO BACK SIDE >>>>

NEW WEST WELLNESS CENTRE

PLEASE MARK WITH A "X" IF APPLIES

- *ARTHRITIS _____
- *BLOOD CLOTS _____
- *CANCER _____
- *COLD HANDS or FEET _____
- *CONSTIPATION _____
- *CONTAGIOUS CONDITION _____
- *DEPRESSION _____
- *DIABETES _____
- *DIZZINESS _____
- *HEADACHES _____
- *HEART ATTACK _____
- *HEMOPHELIA _____
- *HIGH /LOW BLOOD PRESSURE _____
- *HIV POSITIVE _____
- *JAW CLICKING or PAIN _____
- *OSTEOPOROSIS _____
- *PINS or NEEDLES IN HANDS or FEET _____
- *SLEEPING PROBLEMS _____
- *SWOLLEN ANKLES _____
- *VARICOSE VEINS _____

7. ANY OTHER MAJOR SURGURIES, ILLNESSES, OR ACCIDENTS?

THE INFORMATION ON THIS FORM IS CORRECT AND PROVIDES AN ACCURATE SUMMARY OF MY PAST AND/OR PRESENT MEDICAL STATUS. I THE UNDERSIGNED PATIENT (OR LEGAL GUARDIAN IF UNDER 19 YEARS OF AGE) AUTHORIZE TREATMENT FOR MASSAGE THERAPY TO BE RENDERED. SIGNATURE: _____ DATE: _____

I, _____ (PRINT NAME), AGREE TO PAY FOR MY TREATMENT TIME IF I DO NOT CANCEL MY APOINTMENT 24 HOURS PRIOR TO MY TREATMENT TIME.

SIGNATURE: _____ DATE: _____

HOW DID YOU HEAR ABOUT US?

YELLOW PAGES: _____

FRIENDS NAME: _____

DOCTORS NAME: _____

WEB SITE: _____

OTHER: _____