



PROACTIVE HEALTH GROUP

PROFESSIONAL HEALTH CARE FOR THE ACTIVE INDIVIDUAL

Date _____

Name _____ / _____ / _____
last first middle initial

Personal Health # _____ - _____ Male Female

Home Address _____

City _____ Postal Code _____ Home Telephone # _____

Business Telephone # _____ Cell # _____

E-Mail Address _____

Best way to contact you: Home # Work # Cell # Email

Birth Date _____ / _____ / _____ Marital Status M S W D
Y M D

Emergency Contact Name, Address, Phone# _____

Occupation & Company Name _____

Physician's (G.P) Name, Address, Phone# _____

Date of last physical examination _____ / _____ / _____
Y M D

On occasion, our practitioners will communicate your clinical condition with your Physician.

Do you have health insurance other than Alberta Health Care? Yes No

How did you first find out about the clinic?

Patient Referral * Health Care Event Internet Search Physician Referral *

Walk In Sport Team Referral * Trainer Referral * Website Other *

* Please specify the name of the person referring you: _____

Please **mark 1** beside the condition you **have had** in the past

Please **mark 2** beside the condition you **presently have**

Musculoskeletal system

- neck problems
- upper back problems
- shoulder problems
- elbow/wrist problems
- low back problems
- knee problems
- ankle/foot
- arthritis

Nervous system

- numbness
- loss of feeling
- headaches
- dizziness
- fainting
- confusion
- depression
- forgetfulness

Cardio-Vascular-Resp.

- chest pain
- high blood pressure
- difficult breathing
- persistent cough
- coughing phlegm/blood
- lung problems
- varicose veins
- diabetes
- hypoglycemia

Genito-Urinary system

- painful urination
- excessive urine
- scanty urine
- discolored urine

Gastrointestinal system

- poor appetite
- excessive hunger
- abdominal pain
- excessive thirst
- nausea/vomiting
- diarrhea
- constipation
- bloody/black stool
- liver/gallbladder trouble
- weight trouble

Ear, Eyes, Nose, Throat

- eye problems
- vision problems
- ear discharge
- ear pain
- ear ringing
- hearing loss
- sore throat
- allergies
- hoarseness

Female

- premenstrual syndrome
- vaginal discharge
- vaginal bleeding
- pregnancy
- breast pain, and/or lumps

ARE YOU CURRENTLY ON ANY MEDICATIONS?

INDICATE IF YOU UNDER THE CARE OF THE FOLLOWING, WITH NAME, DATE OF LAST APPOINTMENT:

Chiropractor: _____ **Medical Doctor:** _____

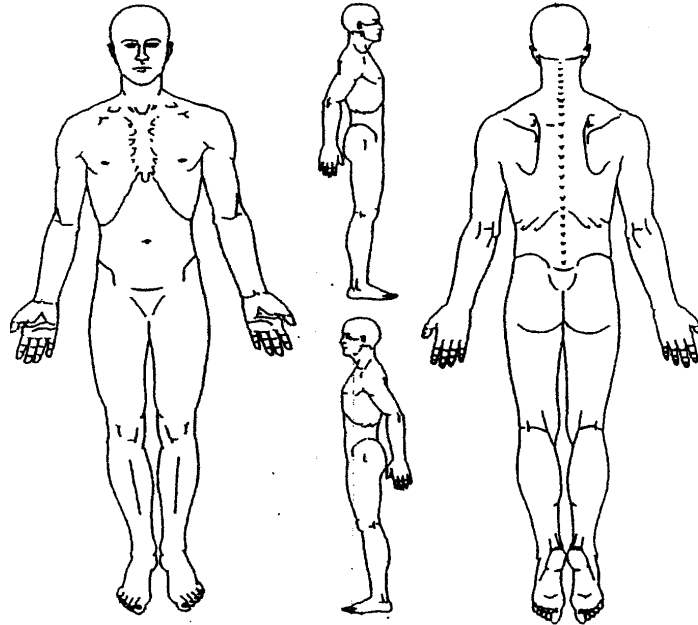
Physio: _____ **Massage Therapist:** _____

Other: _____

DRAWING OF AREAS OF CONCERN

MARK THE AREAS OF YOUR BODY WHERE YOU FEEL THE DESCRIBED SENSATIONS.
USE THE APPROPRIATE SYMBOL, INCLUDE **ALL** AFFECTED AREAS.

- Ache \\\
- Numbness +++
- Pins and Needles ooo
- Burning bbb
- Stabbing sss



DO YOU HAVE ANY OTHER INFORMATION THAT WOULD BE BENEFICIAL TO **YOUR** TREATMENT?

WHAT ARE YOUR TREATMENT GOALS _____

HOW DO YOU LIKE YOUR MASSAGE? Light () Medium () Deep () Not sure ()

DO YOU BRUISE EASILY? YES () No ()

IS THIS A MOTOR VEHICLE ACCIDENT RELATED INJURY? Yes No

IF SO WHEN WAS THE ACCIDENT? _____

IS THIS A WORK RELATED INJURY? Yes No

ARE YOU MAKING A WCB CLAIM? Yes No

IF SO, WHAT WAS THE DATE OF YOUR ACCIDENT? _____

I, (please print) _____ understand that massage therapy given at Proactive Health Group is for the purpose of soft tissue injury relief.

I also understand that the therapist does not diagnose any physical or mental disorders and as such will not prescribe medical treatments nor perform any chiropractic adjustments.

It has been made clear to me that massage therapy is not a substitute for medical or dental examinations and/or diagnosis and that it is recommended that I see a physician for any ailment that I might have.

Because the massage therapist must be aware of any pre-existing conditions, I have disclosed all of my known medical history and take it upon myself to keep this information current and to update the therapist of any changes.

THE INFORMATION THAT I HAVE PROVIDED IS ACCURATE TO THE BEST OF MY KNOWLEDGE. I UNDERSTAND THAT DUE TO THE NATURE OF THE TREATMENT I AM REQUIRED TO NOTIFY THE THERAPIST AND MY FAMILY PHYSICIAN OF ANY CONTAGIOUS AND/OR COMMUNICABLE DISEASES.

Signature _____

Therapist Signature _____

Date _____