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: _____

120-602-12th Ave SW Calgary Ab. T2R 1J3 -- Tel: 403-225-3842 -- Fax: 403-225-3914
info@proactivehealthgroup.ca -- www.proactivehealthgroup.ca

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

Female

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

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

ARE YOU CURRENTLY ON ANY MEDICATIONS?

_____

INDICATE IF YOU UNDER THE CARE OF THE FOLLOWING, WITH NAME, DATE OF LAST APPOINTMENT:
Chiropractor: _____ **Medical Doctor:** _____

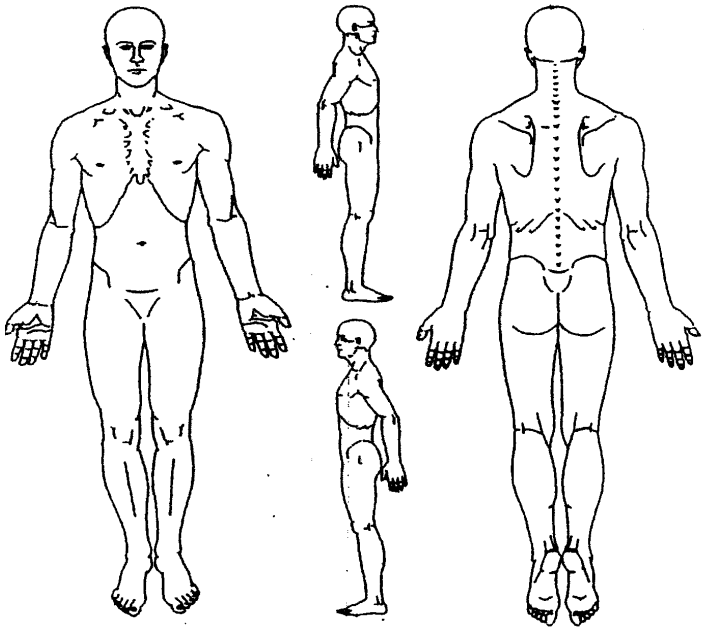
Physio: _____ **Massage Therapist:** _____

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 BENEFITIAL TO **YOUR** TREATMENT?

_____

_____

_____

WHAT ARE YOUR TREATMENTGOALS_____

_____

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 TREATEMENT I AM REQUIRED TO NOTIFY THE THERAPIST AND MY FAMILY PHYSICIAN OF ANY CONTAGIOUS AND/OR COMMUNICABLE DISEASES.

Signature_____

Therapist Signature_____

Date_____