Danielle Third RMT
(306) 715 8759
Client History

Patient Name: ____
(First Name) (Last Name)

Address: ____

Home Phone Number: ____________________ Cell Number: ____________________

Work Number: ____________________

DOB: ____ ____ ____ (dd) (mm) (yy) Occupation: ____________________

Hobbies and Recreation: ____

I would like to thank the person that referred you: ____________________

Reason/Condition For Visit: ____

Duration of condition: ____

____

Cause of Condition: ____

____

Is the pain: a) Stabbing b) Aching c) Burning d) Throbbing e) Dull
f) Other:

Is the pain: a) Constant / Intermittent b) Local / Radiating / Both c) Other

Do you or have you Suffered from any of the following:

( ) Migraine Headaches	( ) Tension Headaches	( ) Difficulty Walking
( ) Hip / Pelvic Pain	( ) Low Back Pain	( ) Mid Back Pain
( ) Upper Back Pain	( ) Neck / Shoulder Pain	( ) Rheumatoid Arthritis
( ) Osteoarthritis	( ) Osteoporosis	( ) Scoliosis
( ) Thyroid Disease	( ) Kidney Disease	( ) Epilepsy
( ) Diabetes	( ) Cancer	( ) Multiple Sclerosis
( ) Varicose Veins	( ) Phlebitis	( ) Atherosclerosis
( ) Stroke	( ) Heart Disease	( ) Asthma
( ) Skin Infections	( ) Psoriasis	( ) Eczema
( ) Dizziness / Fainting spells	( ) High Blood Pressure	( ) Low Blood Pressure

Are you currently pregnant: Y / N If yes, How far along? ____________________

Are you presently taking any prescription or non- prescription medication, natural remedies or supplements?

Name Reason

______________ ____
______________ ____
______________ ____
______________ ____

Have you had any accidents or injuries? (Please explain) ______________________________

____

Have you had any major surgeries? (please explain) ______________________________

____

Are you or have you previously been treated by any of the following:

( ) Specialist Name(s):______________________________
( ) Chiropractor Name(s):______________________________
( ) Massage Therapist Name(s):______________________________
( ) Physio Therapist Name(s):______________________________
( ) Other Therapies Name(s):______________________________

Do you have any allergies? ______________________________

Is there any other information you feel the Massage Therapist should know?

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The information provided and documented on this form is true and accurate to the best of my knowledge.

______________________________ ______________________________
(signature) (date)