

Other therapy / treatment: (past or present, does not have to be related to this visit)

<input type="checkbox"/> Massage Therapy	Date of last visit _____	Location _____
<input type="checkbox"/> Chiropractor	“ _____	“ _____
<input type="checkbox"/> Physiotherapy	“ _____	“ _____
<input type="checkbox"/> Naturopath	“ _____	“ _____
<input type="checkbox"/> Acupuncture	“ _____	“ _____
<input type="checkbox"/> Other _____	“ _____	“ _____

List any Activities, Sports, Hobbies
(ie. Jogging, Hockey, Crafts, Computer, etc)

List any NON-prescription vitamins, minerals or other supplements you are taking:

Please CIRCLE the answer closest to how you PRESENTLY feel: (1 = poor, 5 = excellent)

Quality of Sleep	1	2	3	4	5	Hours of sleep per night (approx.)	_____
Energy Level	1	2	3	4	5	Number of meals you regularly eat per day	_____
Eating Habits	1	2	3	4	5	Number of times you exercise per week	_____
Stress Level	1	2	3	4	5		
Exercise Habits	1	2	3	4	5		
Smoker	Yes	No	Occasional				
Alcohol	Yes	No	Occasional				

Current Condition

Please describe your current condition & symptoms: _____

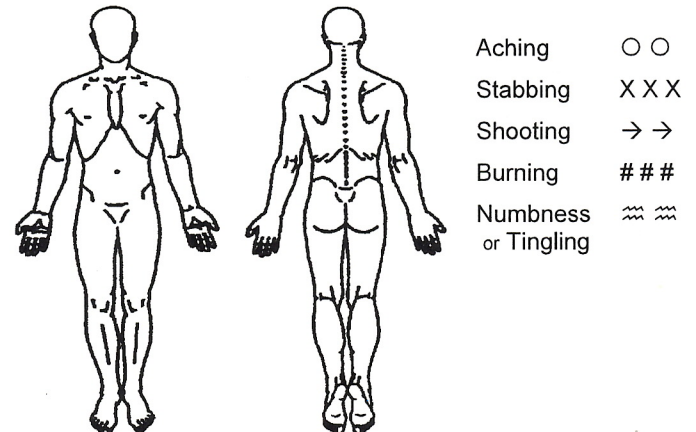
How long have you had this condition? _____

How did it start? _____

What aggravates it? _____

What relieves it? _____

Please indicate on the diagram the nature of your symptoms, using the symbols indicated:



Aching ○ ○
 Stabbing X X X
 Shooting → →
 Burning # # #
 Numbness or Tingling ~ ~ ~

Please Note: Your appointment time has been reserved for you. In courtesy of your therapist & fellow patients, we ask that you provide us with 24 hours notice of cancellation, or a cancellation fee will be charged. Payment for all treatment, whether private or insured, is ultimately the responsibility of the patient.

I authorize the clinic and its associated RMTs to collect my personal and medical information as documented above in order to contact me, and give permission for the clinic to leave messages regarding appointments at any of the contact numbers I have provided above. In addition, I authorize the clinic and its associated RMTs to communicate with my referring MD as deemed necessary for my beneficial treatment. I also understand that my personal and medical information is confidential and will only be disclosed to third parties with my permission.

Signature: _____

Date: _____