

Name: _____ Male Female Date of Birth: _____

Email Address: _____ Would you like to be added to the Filosofi Newsletter? Yes No

Address: _____ City: _____ Postal Code: _____

Home Phone Number: _____ Work Phone Number: _____

Occupation: _____

How did you hear about us? _____

Do you have extended health care Insurance for Massage Therapy? Yes No

Is this your first massage? Yes No

If no, where was your previous care? _____ RMT's name? _____

Medical Doctor's Name: _____ Doctor's Phone Number: _____

Reason for consulting a massage therapist:

- I have no symptoms and I feel well. I am interested in strategies to help me feel even better.
- After my specific problem has been relieved and I understand methods of ensuring it does not return, I am interested in strategies to improve my general health, including regular massage therapy treatments.
- I have a specific problem and require help with this problem only.

Current Health Condition

What brings you in to see us? _____

When did it start? _____ Have you had a similar problem in the past? _____

This condition is: constant comes & goes getting worse

This condition is interfering with: work sleep daily routine sports

Have you consulted others about this condition? Yes No

If so, whom? General Practitioner Chiropractor Massage Therapist Physiotherapist Other

How long has it been since you felt good? _____

What makes your condition: Worse? _____
Better? _____

Please list all major illnesses and surgeries : _____

Have you ever been in a car accident? _____ If yes, when? _____

Do you have any other health complaints? _____

If you are pregnant, when is your due date? _____

Please check any current conditions ("P" is past condition, "C" if current condition)

CARDIOVASCULAR

- High blood pressure
- Low blood pressure
- MI (heart attack)
- Phlebitis
- Stroke/CVA
- Angina
- Pacemaker
- Atherosclerosis
- Chronic congestive heart failure

INFLAMMATORY

- Rheumatoid Arthritis
- Osteoarthritis
- Lupus
- Reiter's Syndrome
- Scleroderma
- Polymyalgia
- Fibromyalgia
- Ankylosing Spondylitis
- Gout

RESPIRATORY

- Chronic Cough
- Bronchitis
- Asthma
- Shortness of Breath
- Emphysema
- Do you smoke?

HEAD/NECK

- Ear problems
- Vertigo
- Blurred Vision
- Earaches
- Vision loss
- Sinus problems

MUSCLE PAIN AND TENSION

- | | |
|--|--|
| Neck | Shoulders |
| <input type="checkbox"/> right <input type="checkbox"/> left | <input type="checkbox"/> right <input type="checkbox"/> left |
| <input type="checkbox"/> front <input type="checkbox"/> back | <input type="checkbox"/> front <input type="checkbox"/> back |

PELVIC

- PID
- Endometriosis

DIGESTIVE

- Crohn's Disease
- Irritable Bowel Syndrome
- Colitis
- Prolonged Constipation
- Prolonged Diarrhea
- Hiatus Hernia
- Reflux
- Ulcers

NERVOUS

- Loss of Sensation
- Epilepsy
- Multiple Sclerosis
- Buerger's Disease
- Neuralgia
- Neuritis
- Spastic Paralysis
- Flaccid Paralysis

SKIN

- Rash
- Sensitivity
- Eczema
- Bruise easily
- Varicose veins
- Psoriasis

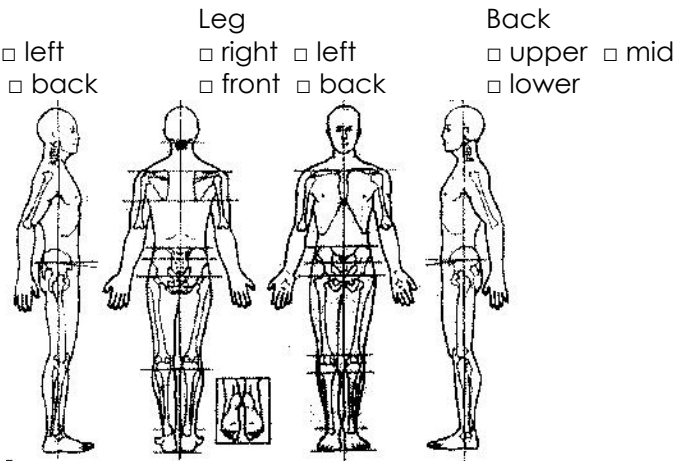
COMMUNICABLE DISEASES

- TB
- Hepatitis
- HIV

OTHER

- Cancer
- Diabetes
- Kidney Disease
- Thyroid Disease
- Insomnia
- Migraines
- Headaches
- Nausea
- Jaw Problems
- Fainting/Dizziness
- Hemophilia
- Chronic Fatigue
- Environmental Sensitivities
- Degenerated discs
- Arthritis
- Internal pins/wires
- Artificial joints

Please indicate the areas you are experiencing pain or discomfort on the diagrams to the right.



I understand and agree that the information I have provided is accurate, current and will be confidential. If at any time there is any change to my health status I will let my Registered Massage Therapist know as soon as possible. Please go to our website www.filosofi.ca to see our complete Privacy Policy.

Signature: _____ Date: _____
Renewal Date: _____