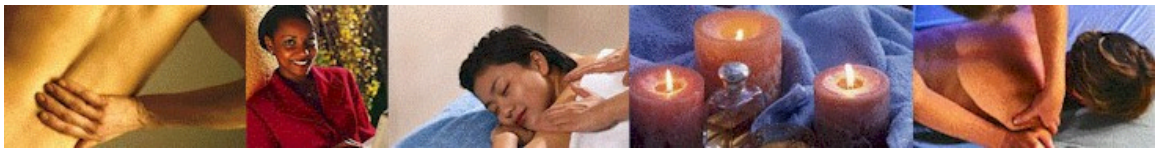


Edgemont Massage Therapy & Holistic Heath Care Clinic

Bay # 10 - 34 Edgedale Dr. N.W.
Calgary, Alberta, T3a 2r4
Phone 241-3772 Fax: 241-3772

Name: _____

Address: _____

Postal Code: _____

Phone: (Home) _____(Work) _____

Email: _____

Age: _____

Occupation: _____

Activities /Hobbies: _____

Are You Currently Taking Any Medication? _____

What? _____

Are you currently receiving chiropractic care or another form of medical treatment?

_____

_____

Have you had an accident, injury or surgery more than 5 years ago?

_____

_____

Have you had an accident, injury or surgery less than 5 years ago?

_____

_____

What is your primary reason for seeing us at our clinic?

_____

_____

_____

_____

_____

_____

_____

_____

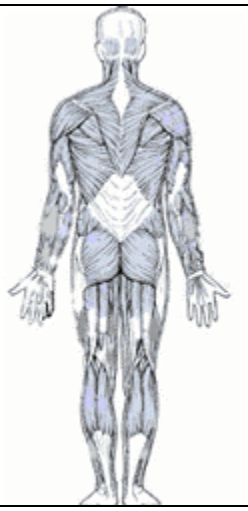
_____

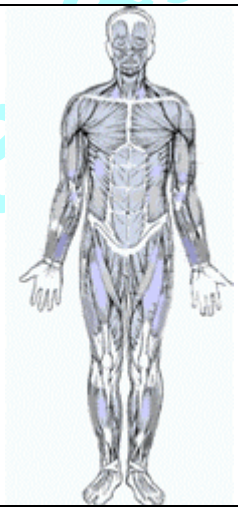
On the following drawing please indicate all areas of:

- Pain PPP
- Stiffness //////
- Numbness NNN
- Shooting SSS
- Constant CCC
- Intermittent iiiii
- Other (Specify) _____

For each area that you mark, please specify the intensity of the feeling as:

- Slight
- Medium
- Harsh





Have you experienced any of the following conditions?

Past	Now		Past	Now		Past	Now	
_____	_____	Arthritis	_____	_____	Back Pain	_____	_____	Neck Pain
_____	_____	Broken Bones	_____	_____	Bursitis	_____	_____	Muscle Spasms
_____	_____	Disc Problems	_____	_____	Fibroymalgia	_____	_____	Joint Problems
_____	_____	Muscle Tension	_____	_____	Osteoporosis	_____	_____	Scoliosis
_____	_____	Strains/Sprains	_____	_____	TMJ Problems	_____	_____	Numbness
_____	_____	Tingling	_____	_____	Sciatica	_____	_____	Hemophilia
_____	_____	Heart Disease	_____	_____	Swollen Feet/Legs	_____	_____	Phlebitis
_____	_____	Poor Circulation	_____	_____	Anxiety	_____	_____	Varicose Veins
_____	_____	Constipation	_____	_____	Excess Stress	_____	_____	Hypoglycemia
_____	_____	Cancer	_____	_____	Long Hours/Stress	_____	_____	Asthma
_____	_____	Allergies	_____	_____	Digestive Problems	_____	_____	Emotional Stress
_____	_____	Physical Stress	_____	_____	Epilepsy/Seizures	_____	_____	Insomnia
_____	_____	Dizziness	_____	_____	Skin Problems	_____	_____	Headaches
_____	_____	Migraines	_____	_____	Tumor	_____	_____	Stroke
_____	_____	Chronic Fatigue Syndrome	_____	_____	High Blood Pressure			
						For Women Only		
						_____	_____	PMS
						_____	_____	Menstrual Cramps
						_____	_____	Menopause
						_____	_____	Pregnancy

Are you currently having any of the following conditions?

- Pregnancy
- Flu/Cold
- Infection
- Inflammation
- Fever
- Contagious Disease

What aggravates your condition?

Nutrition and lifestyle assessment:

1. How much coffee do you drink per day? • Zero • 1-2 • 3-4 • 4-5 • 6+
2. How much pop do you drink per day? • Zero • 1-2 • 3-4 • 4-5 • 6+
3. How many drinks of alcohol per week do you consume? • Zero • 1-2 • 3-4 • 4-5 • 6+
4. Do you smoke? • Yes • No
5. How much do you smoke, in packs? • ¼ • ½ • ¾ • 1 • 1+
6. How often do you exercise at least 30 minutes each week? • Zero • 1-2 • 3-4 • 4-5 • 6+
7. What types of exercise do you participate in:

   _____

   _____
8. Are you on any medications at the moment? • Yes • No

   If yes what are they:

   _____

   _____
9. Do you feel that you get an adequate amount of sleep? • Yes • No
10. Do you feel that you are always tired? • Yes • No
11. How much water do you drink each day, glasses? • 1-3 • 4-6 • 7-9 • 10-12
12. How would you rate your diet? • Very Good • Good • Poor
13. Are you taking any nutritional supplements? • Yes • No
14. If yes, what nutritional supplements are you taking

    _____

    _____
15. Have you had massage therapy before? _ • Yes • No _____

Other information that you feel we should be aware of:

_____

_____

_____

_____

_____

_____

_____

_____

Massage Therapy Permission To Treat & Information Agreement

I understand that massage is given here for the purpose of stress reduction, relief from muscular tension, spasm, or for increasing circulation or energy flow. I understand that the massage therapist does not diagnose illness, disease, or any other physical or mental disorder. As such, the massage therapist does not prescribe medical treatments or pharmaceuticals nor do they perform spinal manipulations. It has been made clear to me that massage is not a substitute for medical examination or diagnosis and that it is recommended that I see a physician for any physical ailment that 1 might have.

I have stated all my known medical conditions and take it upon myself to keep the massage therapist updated on my physical health. The primary focus of the massage therapists is treatment of musculoskeletal conditions. Therefore it is acknowledged that I waive the massage therapists of all responsibility or liability, implied or direct, as it may relate to conditions that are not musculoskeletal in nature i.e. cancer, infections, and all organic based conditions.

By signing this document, I acknowledge that I have read and understood the above statements and agree to treatment based on this document. Therefore, I intend this consent to cover the entire course of treatment for my present condition/s and for any conditions for which I may seek treatment for in the future.

Signature_____Date_____

Witness_____Date_____