Christie de la Perrelle, R.M.T.
Registered Massage Therapist

The questions on this confidential intake form are designed to give your therapist a better and more complete understanding of your health and lifestyle. This information assists in creating the most effective treatment plan for your individual needs. Thank you for taking the time to fill out this form.

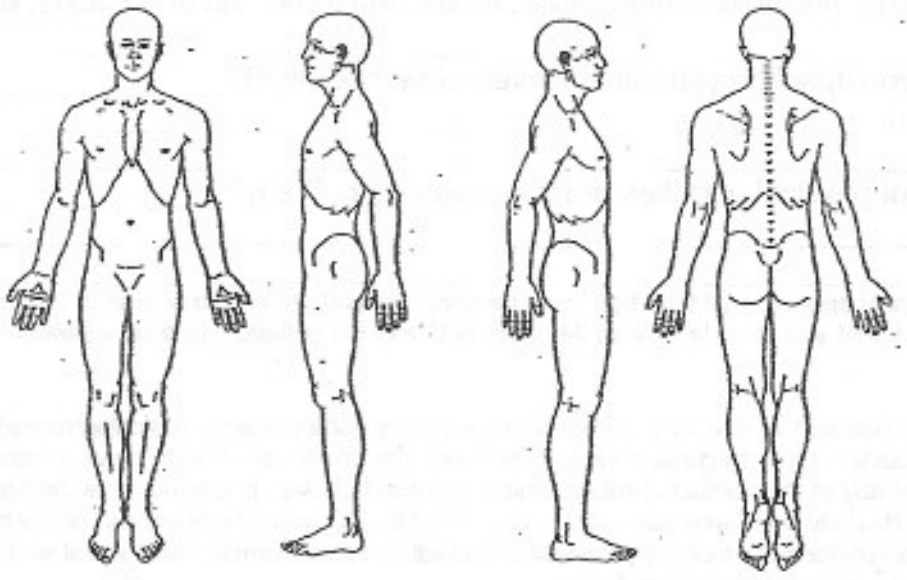
Name _____ Date _____
Address _____ Tel (H) _____
_____ (C) _____
Occupation _____ (W) _____

Date of Birth ____/____/____ Male__ Female__

Family Doctor: _____
Please indicate your health care practitioners:
Accupuncture:_____ Physiotherapist:_____
Chiropractor:_____ Other:_____
Naturopath:_____
Please list out your reason(s) you are seeking treatment

_____
_____
_____

Please indicate the area(s) of your discomfort by marking with an 'X' on the pictures below:



Please list all injuries you have sustained, even if they appear unrelated to your current condition:_____
_____

Do any of the following conditions apply (or have applied) to you? (Please check)

( ) Heart Attack
( ) High/Low Blood Pressure
( ) Stroke or Aneurysm
( ) High Cholesterol
( ) Pace Maker
( ) Heart Disease
( ) Varicose Veins
( ) Blood Clots
( ) Bruise easily
( ) Other Circulatory Conditions
( ) Diabetes
( ) Kidney Disease
( ) Other Urinary conditions

( ) Chronic Muscle Pain
( ) Shooting/Radiating Pain
( ) Joint Pain/Stiffness
( ) Arthritis
( ) Osteoporosis
( ) Bone Fractures
( ) Joint Dislocations
( ) Rods/Pins/Plates/Shunts
( ) Hyper/Hypo Thyroid
( ) Fatigue
( ) Depression
( ) PMS Symptoms
( ) Menopause
( ) Pregnancy
( ) Digestive conditions

( ) Headaches/Migraines
( ) Dizziness/Vertigo
( ) Nausea
( ) Spinal Injury
( ) Epilepsy/Seizeures
( ) Other Neurological conditions
( ) Cancer
( ) Allergies
( ) Skin Conditions
( ) Other Contagious Conditions
( ) Asthma
( ) Other Respiratory conditions

Any other conditions not listed above?: _____

Please list all medications you are taking: _____

Please list any Non-prescription vitamins or other supplements you are taking: _____

Known Allergies (including medications, foods, seasonal, oils and lotions, etc): _____

How would you describe your stress level? (low/mod/high): _____
Please explain: _____

What forms of physical activities are you involved in, if any? _____

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.

I authorize the clinic and its associated RMT's 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 RMT's 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:** _____

Care Card # _____ **ICBC Claim #** _____