ActiveLiving
MASSAGE THERAPY

DOWNTOWN
225 Metcalfe St.
6th Floor, Suite 217 // K2P 1P9
(Between Somerset St. & Cooper St.)

KANATA
263 Escarpment Cr.
K2T 0L5
(North off Hwy 417 @ Terry Fox Dr.)

CONTACT
613.878.2246
info@activelivingmassage.com

CONTACT INFORMATION

First Name		Last Name
Birthdate (DD / MM / YYYY)		Occupation
Street Address		Apt / Suite
Postal Code	Province	Country
Main Phone No.		Alternate Phone No.
Email Address		
How did you hear about the clinic?		

CURRENT CONDITION

Please describe your current pain and symptoms

How long have you had these current condition / symptoms?

Have you had this condition / symptoms before?	☐ No	☐ Yes	When?

What makes it better (positions / activites / movements)?

What makes it worse (positions / activites / movements)?

What percentage of the day does it bother you?

☐ 25% (Intermittent)	☐ 50% (Occasional)	☐ 75% (Frequent)	☐ 100% (Constant)

Does this affect you at:

☐ Work	☐ Play / Activites / Exercise	☐ Sleep	☐ Romance / Love life

Please circle the pain number that most accurately represents your current pain level below:

1 2 3 4 5 6 7 8 9 10

YOUR MEDICAL PRACTIONER'S INFORMATION

First Name		Last Name
Date Last Seen (DD / MM / YYYY)		Reason for Visit
Recent Medical Testing		
☐ X-Ray	☐ Blood Test	☐ Other
Permission to contact your medical doctor (signature)		

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FAMILY HISTORY

Please state who has/had each condition (e.g. Maternal grandma), how old they were when diagnosed, and what type (e.g. Lung Cancer). Have they passed away?

Condition	Who	Age of Diagnosis	Type	Have They Passed Away?	
				☐ No	☐ Yes
				☐ No	☐ Yes
				☐ No	☐ Yes
				☐ No	☐ Yes

PERSONAL HEALTH HISTORY: The following lists a variety of conditions that patients may experience. Please read through the list and check the box next to each condition that applies to you.

GENERAL CURRENT CONDITIONS

- ☐ Recent accident such as a fall, whiplash, or blood to the head
- ☐ Spinal / back / neck problems
- ☐ Muscle spasms
- ☐ Restricted movement
- ☐ Numbness or tingling of hands or feet or radiating pain
- ☐ Headaches or migraines
- ☐ Sinus problems
- ☐ Nausea
- ☐ Depression
- ☐ Anxiety or difficulty with stress
- ☐ Dizziness or vertigo
- ☐ Vision problem
- ☐ Hearing problem
- ☐ Sleeping trouble
- ☐ Asthma or breathing problem
- ☐ Digestive trouble
- ☐ Heartburn / Acid reflex
- ☐ Menstrual problems
- ☐ Jaw or mouth problem
- ☐ Arm, shoulder, elbow, or hand problem
- ☐ Leg, hip, knee, or foot problem

DIAGNOSED CONDITIONS

- ☐ Born with bone or joint disorder
- ☐ Osteoporosis
- ☐ Degenerative arthritis / Osteoarthritis
- ☐ Rheumatoid arthritis
- ☐ Compression fracture
- ☐ Heart attack or heart disorder
- ☐ History of stroke or aneurysm
- ☐ Cancer
- ☐ Diabetes
- ☐ Gout
- ☐ Lupus
- ☐ Ankylosing spondylitis
- ☐ Immune suppression treatment or disorder from chemotherapy, organ transplant, drug, etc
- ☐ 3 or more months of steroid medications or intravenous drugs (past or present)
- ☐ Tuberculosis
- ☐ Hepatitis B or HIV infection
- ☐ Multiple sclerosis
- ☐ Thyroid or hormone disorder
- ☐ High blood pressure
- ☐ Convulsions/epilepsy

SPECIFIC PAIN IN THE BODY

- ☐ Pain or electric shocks in the arms or legs when moving neck
- ☐ Leg pain worse with exercise
- ☐ Numbness of inner thighs
- ☐ Back pain with urinary problems
- ☐ Severe pain to interrupts sleep
- ☐ Constant pain that doesn't improve by changing positions or by lying down

OTHER

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PERSONAL HEALTH HISTORY (CONT'D)

Describe **ANY** surgeries / hospitalization / motor vehicle accidents / sport accidents / personal or work accidents / fractures / dislocations / and/or illnesses you have had and the dates.
Please list any medications you presently take and what condition you are taking them for
Known Allergies (including medications, foods, seasonal, oils and lotions, etc.)
Do you have any internal pins, wires, or artificial joints? If yes, please indicate where

FOR WOMEN: Are you pregnant?	☐ No	☐ Yes	If yes, date of last period

TREATMENT HISTORY

	Name / Location	Date of Last Visit (DD / MM / YYYY)	Years of Care **OR** # of Treatments	Result of Treatment Excellent / Good / Fair / Poor
Massage Therapy				
Chiropractor				
Physiotherapy				
Other (specify)				

DISCLAIMER

PLEASE NOTE: Your appointment time has been reserved for you. In courtesy of your therapist and fellow patients, we ask that you provide us with 24 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 agree with the above statement.

I authorize the clinic and it's associated practitioners to collect my personal and medical information as documented above in order to contact me, and Give permission to the clinic to leave messages regarding appointments at any of the contact numbers I have provided above. In addition, I authorize the clinic and it's associated practitioners to communicate with my referring MD As the 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 (DD / MM / YYYY)