Kevin G. Heath

Registered Massage Therapist

Date (mm/dd/yyyy): ___/___/_______

Client Full Name: ____ **Sex: Male** ☐ **Female** ☐ _____ ☐

Birthdate (mm/dd/yyyy): ___/___/_______ **Email Address:** ____________________________

Home Phone: __________________________ **Cell Phone:** ____________________________

Address: ____

City: ____________________________ **Province:** __________ **Postal Code:** _____________

Referred by Doctor? Yes ☐ **No** ☐ **If yes, your Care Card No. is:** _________________________

Doctor: _________________________ **Referred to Clinic by:** _________________________

____

Are you presently on ICBC, WCB, or Disability Claim? Yes ☐ No ☐

If yes, please see "Information Regarding Claim" section, bottom of page 2

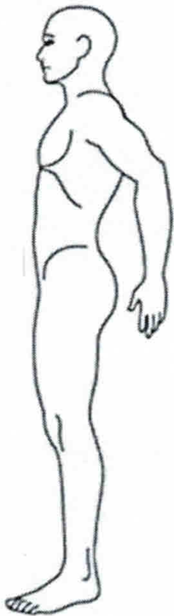
Are you seeking therapeutic massage for:

Stress/relaxation only ☐ or **Treatment of specific pain/discomfort** ☐

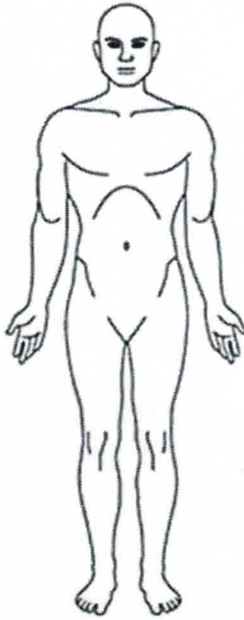
Please indicate on the following diagrams your area of concern and describe, below, the nature of your concern.

Please use the following symbols on the diagram to indicate areas of:

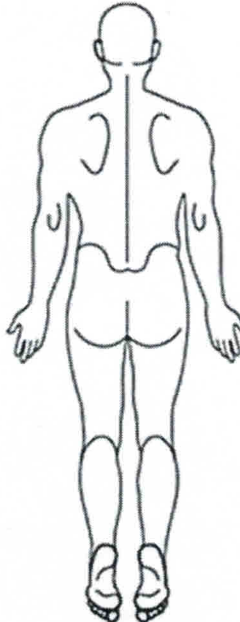
xxxx = Pain //// = Stiffness oooo = Numbness _______ = Other (Specify _______________)



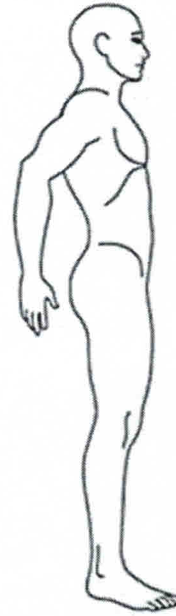
Left



Front



Back



Right

The above complaint(s) are: Constant ☐ On and Off ☐

The above complaint(s) are related to (check more than one if necessary):

Posture ☐ Occupation ☐ Motor Vehicle Accident ☐ Injury ☐ Diagnosed Condition ☐

Make a mark (//) along the line at a point which represents your current level of pain/discomfort in your major areas of concern, somewhere between "No Pain/Discomfort At All" and "Pain as Bad As it Could Be"

Describe when you first noticed it including the date of onset: ______________________________

____

List past injuries/accidents/surgeries/diseases: (When) ______________________________

____

Do you frequently get headaches? (How often): ______________________________

____

List medications, supplements or other medical treatments you are currently taking: ______________

____

List medications, supplements or other medical treatments you are currently taking: ______________

____

Do you have any allergies? ______________________________

Current Occupation(s) ______________________________

Previous occupation(s) if related to current concern(s): ______________________________

In your opinion, how is your overall health (psychological and physical): ______________________________

____

Do you have a major source of stress? (Physical or Psychological) ______________________________

Do you exercise regularly? How often and what type? ______________________________

Have you experienced a major change in your life in the past year? ______________________________

Have you been treated by a Registered Massage Therapist before? ______________________________

Have you been treated by a Physiotherapist/Chiropractor/Naturopathic doctor? ______________________________

Kevin G. Heath is an opted out therapist and does not directly bill MSP, ICBC, WCB or private plans. Payment is required at the time of service. If you have extended medical coverage, your plan may reimburse part of the treatment fee.

Initial Assessment and Treatment	**$115**
Subsequent Treatment (45 Minutes)	**$95**
Subsequent Treatment (60 Minutes)	**$110**

Your treatment time is reserved for you.

Please Inform us 24 hours I advance if you are unable to keep your appointment otherwise a charge will be rendered for missed appointments. I have read and agree with the above terms and conditions:

Name: ______________________________ **Signature**: ______________________________

Medical Health History:

This information is important to the therapist in establishing your treatment plan.

Circle any of the below listed conditions that are *presently* affecting you.

Indicate with an H (for history) and year of occurrence above any condition that has troubled you in the past.

MUSCULO-SKELETAL:

Neck pain Back Pain Aching Joint Aching Muscles Muscle Cramps Stiffness

Muscle Weakness Limited Joint Movement Crackling Joints Painful Joints Rib Pain

Swollen Joints Pain When Walking Frozen Shoulder Tendonitis Bursitis

HEAD AND NECK:

Whiplash Headaches (and frequency) Neck Tension Facial Pain Eye Problems

Torticollis Hearing Problems Earaches or Ear Infections Lumps in Neck

Problems Swallowing Swollen Glands Frequent Sore Throat Mental Fogginess

Impaired /Altered Head Movement

NERVOUS SYSTEM:

Numbness or Tingling Abnormal Sensation Sciatic Problem Twitches or Tremors

Frequent Anxiety/Fear Depression Paralysis Epilepsy Frequent Sweating

CARDIO-VASCULAR:

Heart Disease/Condition Heart Attack Heart Palpitations Chest Pains Stroke

Phlebitis Anemia High Blood Pressure Low Blood Pressure Arteriosclerosis

Bruise Easily Thrombosis Aneurysm Excessive Bleeding Varicose Veins

Edema (swelling in legs) Frequent Cold Hands/Feet Rheumatic Fever