The Loft - Registered Massage Therapy & Wellness
25 Milling Road
Cambridge, Ontario, N3C 1C3
www.carolynmurrayrmt.ca

New Client Registration

An accurate health history is important to ensure that it is safe for you to receive massage treatment.
If your health status changes in the future, please let me know.

Client Name: Address:

Date Of Birth: Occupation:

Telephone (Home): (Business): (Cell):

Email:

Emergency Contact: Relationship: Contact:

Where Did You Hear About Us?

What Is Your Primary Complaint?

Please Indicate Any Conditions You Are Experiencing or Have Experienced In The Past

Respiratory
- □ Chronic Cough
- □ Shortness of breath
- □ Bronchitis/Pneumonia
- □ Asthma
- □ Emphysema

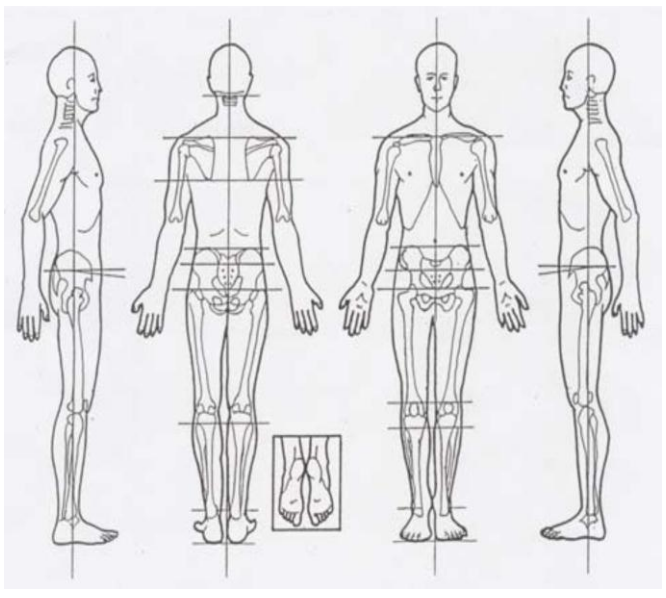
Skin
- □ Psoriasis
- □ Eczéma
- □ Non Infectious Skin Condition
- □ Infectious Skin Condition
- □ Open Sores

Infections
- □ Hepatitis (Type____)
- □ TB
- □ HIV
- □ Herpes
- □ Other _____

Women
- □ Pregnant
  Due Date _____
- □ Menopause
- □ Other _____
  _____

Cardiovascular
- □ High Blood Pressure
- □ Low Blood Pressure
- □ Heart Disease
- □ Phlebitis
- □ Pace Maker Or Similar
- □ Stroke / Cva

Other Conditions
- □ Loss Of Sensation
- □ Diabetes
  Type___ Onset___
- □ Allergies
- □ Epilepsy
- □ Arthritis
- □ Osteoporosis
- □ Dizziness



Head / Neck
- □ Vision Problems
- □ Vision Loss
- □ Ear Problems
- □ Hearing Loss
- □ Headaches/Migraines

Other Health Condition
- □ _____
- □ _____
- □ _____

Soft Tissue/Joint Discomfort
□ Neck □ Low Back □ Mid Back □ Upper Back □ Shoulders
□ Arms □ Hands □ Legs □ Knees □ Feet/Ankles
□ Hips □ Spinal □ Other _____

Medications	Condition it Treats
1	
2	
3	

Drug Allergies	Reactions
1	
2	
3	

Have You Taken any Anti-inflammatory, Pain Killers, Muscle Relaxer, Mood Altering drugs in the last 2hours? If yes please list_____

Surgeries/Injuries/Motor Vehicle Accidents (Past or Present)	
1	Date
2	Date

Other Medical Conditions or Family History

Special Note – Internal Pins/Wires/Rods/Artificial Joints, Special Equipment

Primary Care Physician
Name
Address
Telephone

Other Natural Health Modalities Used in Past or Present

Acupuncture	When?_____	☐ Osteopathy	When?_____
Chiropractic	When?_____	☐ Physiotherapy	When?_____
Homeopathy	When?_____	☐ Other	When?_____
Massage Therapy	When?_____	☐ Other	When?_____
Naturopathy	When?_____	☐ Other	When?_____

Exercise	Frequency
1.	☐ 1x weekly ☐ 2-4x weekly ☐ monthly ☐ infrequently
2.	☐ 1x weekly ☐ 2-4x weekly ☐ monthly ☐ infrequently
3.	☐ 1x weekly ☐ 2-4x weekly ☐ monthly ☐ infrequently

How Is Your Overall General Health?

I certify that to the best of my knowledge this information is complete and accurate.

Client Signature _____ Date_____

Health History Update
1._____
2._____
3._____
4._____

BP Update	
Date_____	/
Date_____	/
Date_____	/
Date_____	/