Cambie Village Massage Therapy

Name _____ Date _____

Address _____ Date of birth _____

_____ Occupation _____

Phone #'s Home _____

Work _____ Cell _____

Email address _____
May we contact you via mail or email yes no
How did you hear about us _____

Please describe the nature of your condition….

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

**OFFICE USE ONLY**

PVT / MSP / ICBC Receipt email / paper

PHN _____MD_____

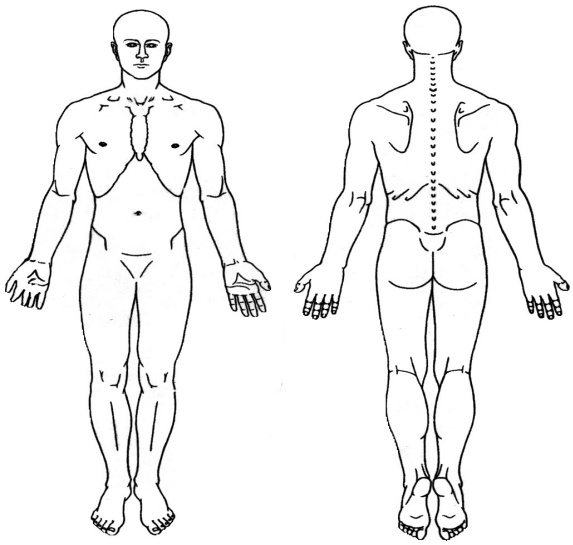
Claim # _____MVA date _____

Adjustor _____

Lawyer _____

Insurance_____

Policy_____ID_____



**Please indicate area(s) of concern**

**Patient health history** Please indicate if you believe if any of the following apply to you?
(P = past C = current) Circle if necessary

| | | |
|---|---|---|
| Heart Condition | Inflammatory condition | Cancer |
| High / Low Blood Pressure | Arthritis (Osteo/Rheumatoid ) | Hepatitis / HIV |
| Circulatory conditions | Osteoporosis | Fibromyalgia |
| Varicose Veins | Respiratory Condition | Mental health |
| Bruise easily | Asthma | |
| Spinal/Head Injury | Digestive Disorder | Allergies: |
| Epilepsy or other seizures | Diabetes | |
| Neurological Condition | Skin Condition | |
| Numbness/Tingling | Dislocations | Medications: |
| Headaches / Migraines | Fractures | |
| Dizziness / Fainting /Nausea | Menstrual problems/Pregnancy | |

**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. Payment for all treatment, whether private or insured, is ultimately the responsibility of the patient.

**Signature:** _____