New Moon Massage Therapy and Wellness Centre

113 Marion St.
R2H 0T2
Phone (204) 615-8888

NAME_____ **TODAY'S DATE**_____

ADDRESS_____ **PHONE (RES)**_____

POSTAL CODE_____ **PHONE (BUS)**_____

CITY/PROV_____ **PHONE (CELL)**_____

EMERGENCY CONTACT_____ **EMERGENCY PHONE**_____

DATE OF BIRTH_____ **EMAIL**_____

PHYSICIAN'S NAME_____ **CHIROPRACTOR'S NAME**_____

OCCUPATION_____

How did you hear about us?_____

Have you ever been treated by a Massage Therapist before?_____

If yes, how long ago was your last treatment?_____

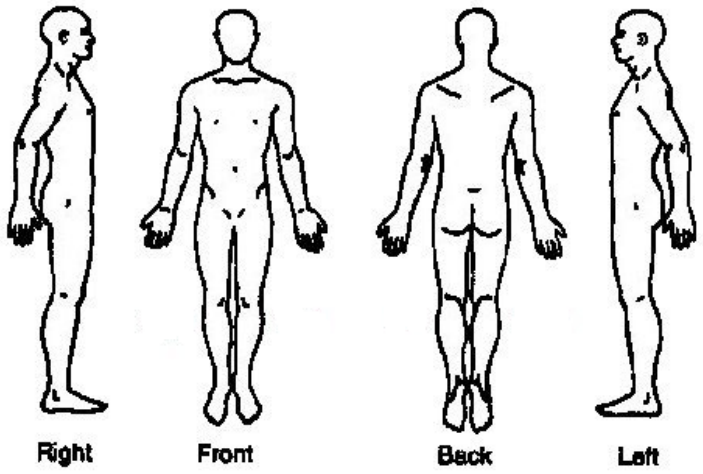
Are you currently under medical supervision? If yes, please specify:_____

_____

Are you presently taking any medication, herbal supplements? If yes, please specify:_____

_____

PLEASE INDICATE THE LOCATION OF YOUR SYMPTOMS (if any)



Have you been treated by any of the following in the past 2 years?

□ Massage Therapist □ Physiotherapist □ Physician
□ Specialist □ Homeopath/Naturopath □ Chiropractor

Please indicate conditions you are currently experiencing and conditions that you have experienced In the past:

□ Heart conditions □ High/Low blood Pressure □ Disorders of the stomach
□ Circulatory conditions □ Respiratory conditions □ Fainting/Dizziness
□ Seizures □ Nervous system disorders □ Diabetes (Type 1, 2 or Gestational)
□ Fractures □ Osteoporosis □ Strain/Sprains
□ Arthritis □ TMJ problems □ Fibromyalgia
□ Skin conditions □ Grinding/Clenching Jaw □ Communicable diseases
□ Infectious diseases □ Whiplash □ Athletes Foot
□ Sinus problems □ Cancer □ Frequent colds/flu
□ Anxiety □ Frequently tired □ Headaches
□ Low back pain □ Depression □ Migraines
□ Mid back pain □ Shoulder/neck pain □ Allergies/Intolerances

Others: _____

_____

LIFESTYLE: (Please circle)

Exercise? Y or N If yes, how often and what type? _____
Smoker? Y or N
Nutrition/Diet: Poor / Moderate / Good
Stress level: Low / Moderate / High How do you manage everyday stresses? _____

WOMEN ONLY:

□ Frequent Menstrual cramping
□ Pelvic inflammation/Infection
Are you pregnant? Y or N If yes, how far along? _____
Any complications with previous pregnancies? _____

MEN ONLY:

□ Prostate/urinary infection

_____

Are we permitted to contact you by phone, email, or mail? Y or N

All information in client files will be kept completely confidential and are only intended for the use of New Moon Massage Therapy and Wellness Centre and its therapists. This confidential information will not be released without your written consent. New Moon Massage Therapy and Wellness Centre and its therapists are not responsible for any unforeseen medical complications.

New Moon Massage Therapy and Wellness Centre requires a minimum of 24 HOURS notice for cancellations. I consent to be charged my full appointment fee if I have not provided New Moon Massage Therapy and Wellness Centre with 24 HOURS notification prior to a cancellation.
X_____(Please initial here)

X_____Date:_____
signature