Optimum Performance Centre

CONFIDENTIAL CLIENT INFORMATION

Date:

Name: _____

Birth Date: M_____/D_____/Y_____ **Gender:** ☐ Male ☐ Female

Address: _____

City / Town: _____ **Postal Code:** _____

Home Phone: _____ **Work Phone:** _____

Cell: _____ **E-mail:** _____

Marital Status: _____ **Number of Children:** ____ **Spouse / Parent:** _____

Occupation: _____ **Employer:** _____

Contact Person: _____ **Phone:** _____ **Relationship:** _____

WCB Claim: ☐ Yes ☐ No **Motor Vehicle Accident:** ☐ Yes ☐ No

How did you hear about us?: _____

Previous Massage Therapy: ☐ Yes ☐ No

Name of Massage Therapist: _____

Medical Doctor: _____ **Date of Last Exam:** _____

Chiropractor: _____ **Presently Being Treated:** ☐ Yes ☐ No

Physiotherapist: _____ **Presently Being Treated:** ☐ Yes ☐ No

Medication or Prescription Drugs: _____

Vitamins / Minerals: _____

Female: Pregnant ☐ Yes ☐ No

Reason for Appointment: _____

Area(s) of Complaint: ☐ Neck ☐ Shoulder ☐ Mid-back ☐ Low back

☐ Other: _____

Date Symptoms Appeared or Accident Happened: _____

Recurring or Past Problem: ☐ Yes ☐ No

Intensity: ☐ Mild ☐ Moderate ☐ Severe

Timing: ☐ Constant ☐ Comes and goes

Interferes With: ☐ Work ☐ Sleep ☐ Daily Routine ☐ Other: _____

Aggravating Factors: _____

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Previous Accidents or Injuries (car, falls, sports, etc.): _____

_____

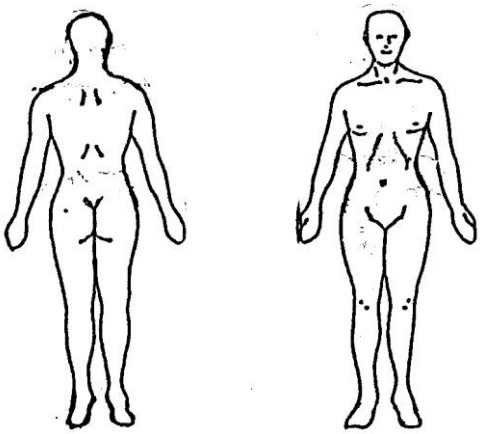
_____

Exercise / Sport Involvement: ☐ Yes ☐ No

Type / Frequency: _____

Please indicate the location and type of pain you are currently experiencing:

Aching: *aaaaaa*
Sharp: ^^^^^
Burning: *xxxxx*
Shooting: +++++
Stabbing: *////////*
Numbness: *nnnnn*
Spasm: *oooooo*



Check those you are suffering from or have recently suffered from:

☐ Allergy	☐ Poor posture	☐ Asthma
☐ Sciatica	☐ Tuberculosis	☐ Colds
☐ Spinal curvature	☐ Bruise easily	☐ Arthritis
☐ Difficult digestion	☐ Nausea	☐ Diabetes
☐ Kidney infection	☐ Depression	☐ Anemia
☐ Nervousness	☐ Rapid heart beat	☐ Bursitis
☐ High / low blood pressure	☐ Stroke	☐ Ear noises
☐ Lumps on breast	☐ Alcoholism	☐ Cancer
☐ Irregular menstruation	☐ Hot flashes	☐ Swelling
☐ Neck pain or stiffness	☐ Varicose veins	☐ Fatigue
☐ Deep vein thrombosis	☐ Headaches	☐ Nose bleeds
☐ Motor vehicle accident	☐ Cramps	☐ Deafness
☐ Polio	☐ Chest pains	☐ Ulcers

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WAIVER

I understand that the massage I receive is provided for the basic purpose of relaxation, stress reduction, and relief of muscular tension. I further understand that massage should not be construed as a substitute for medical examination, diagnosis, or treatment and that I should see a physician, chiropractor, or other qualified medical specialist for any physical ailment that I am aware of.

I understand that massage therapists are not qualified to perform skeletal adjustments, diagnose and / or prescribe, and that nothing said in the course of the session should be construed as such.

Because massage is contraindicated under certain conditions, I affirm that I have stated all my known medical conditions, and answered all questions honestly. I agree to keep the therapist updated as to any changes in my medical profile, and understand that there shall be no liability on the therapist's part should I forget to do so.

It is also understood that any illicit or sexually suggestive remarks or advances made to the massage therapist will result in immediate termination of the session, and I will be liable for payment for the full scheduled appointment.

_____ _____

Client Signature Date