Client Medical History

Name:	Date:
Address:	Postal Code:
Email:	Date of Birth:
Phone Number:	Alt Phone Number:
Occupation:	Physician's Name:

How did you hear about B.V Massage Therapy?

Have you previously seen a:
- ☐ Chiropractor
- ☐ Physiotherapist:
- ☐ Massage Therapist
- ☐ Or other health care professional

Please list any previous surgeries, injuries or illnesses:

Please list all medications you are currently taking:

Have you been, or are you now, affected by any of the following?

General

- ☐ Allergies
- ☐ Anemia
- ☐ Skin Trouble
- ☐ Insomnia
- ☐ Edema
- ☐ Fatigue
- ☐ Cancer
- ☐ Diabetes
- ☐ Herpes
- ☐ Polio
- ☐ Osteoporosis

Digestion

- ☐ Difficulty Swallowing
- ☐ Heartburn
- ☐ Liver Problems
- ☐ Abdominal Pain
- ☐ Ulcers
- ☐ Constipation

Cardiovascular

- ☐ Chest Pain
- ☐ Shortness Of Breath
- ☐ High Blood Pressure
- ☐ Heart Palpitations
- ☐ Heart Attack
- ☐ Heart Disease
- ☐ Ankle Swelling
- ☐ Varicose Veins
- ☐ Rheumatic Fever
- ☐ Poor Circulation

Head and Neck

- ☐ Eye Problems
- ☐ Headaches
- ☐ Sinus Trouble
- ☐ Sinus Trouble
- ☐ Thyroid Trouble
- ☐ Neck/Shoulder Tension
- ☐ Torticollis
- ☐ Whiplash

Respiratory

- ☐ Cough
- ☐ Asthma
- ☐ Rib Pain on Inspiration
- ☐ Pneumonia
- ☐ Emphysema
- ☐ Chronic Bronchitis
- ☐ Tuberculosis

Urinary

- ☐ Kidney Disease
- ☐ Urinary Tract Infection
- ☐ Frequent Urination

Locomotor

- ☐ Back/Neck Pain
- ☐ Painful Joints
- ☐ Bursitis
- ☐ Tendonitis
- ☐ Limited Movement
- ☐ Cracking Joints
- ☐ Poor Posture
- ☐ Back/Neck Pain
- ☐ Painful Joints
- ☐ Bursitis
- ☐ Tendonitis
- ☐ Limited Movement
- ☐ Cracking Joints
- ☐ Poor Posture
- ☐ Frozen Shoulder
- ☐ Osteoarthritis
- ☐ Arthritis
- ☐ Broken Bones
- ☐ Sprains/Strains

Nervous System

- ☐ Multiple Sclerosis
- ☐ Parkinson's
- ☐ Anxiety
- ☐ Epilepsy
- ☐ Sciatica
- ☐ Numbness/Tingling
- ☐ Dizziness
- ☐ Muscle Weakness
- ☐ Paralysis
- ☐ Depression

Women Only

- ☐ Pregnancy