Vitality for Life
HEALTH CENTER
560 Bryne Drive, Unit 1A
Barrie, ON L4N 9P6
(705) 733-2033


Name:________________________________
Address:______________________________
City:______________ Prov:______________
Postal Code:___________________________
Phone(H):____________(W):______________
Current Date:__________________________
EMAIL: _______________________________

Referred By:___________________________
Family Physician:_______________________
Address:___________________________
Phone:____________________________
Emergency Contact:______________________
Phone:____________________________

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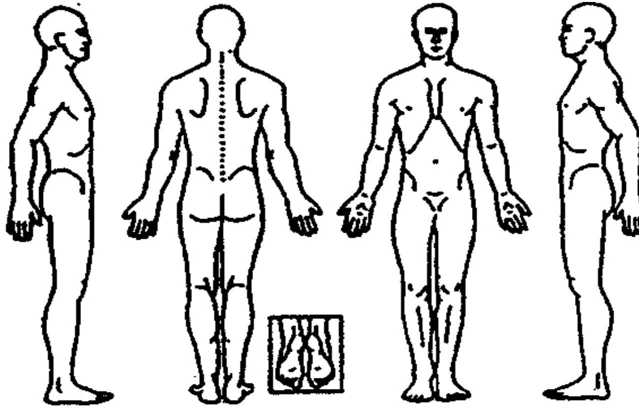
☐Female ☐Male Date of Birth:___________
Occupation: ___________________________
What is your general health status?___________
What is your dominant hand?
☐ Left ☐ Right
What is your primary sleeping position?
☐ Side ☐ Back ☐ Front
Do you smoke? ☐ No ☐ Yes
If yes, how much per day:___________
Are you currently taking **ANY** medication?
☐ No ☐ Yes
Name medication and condition including **supplements**:
________________________________
________________________________
________________________________
________________________________

Are you, or are you possibly pregnant?
☐ No ☐ Yes
Expected due date:________________
Do you exercise regularly? ☐ No ☐ Yes
Frequency: ____x/week
What are your recreational activities:
________________________________
________________________________
Do you have any internal pins, wires, artificial joints or other special equipment (such as a pacemaker or hearing aid)?
☐ No ☐ Yes
If yes, please explain:
________________________________
Have you ever seen a Massage Therapist? _____
If yes, what is their name? ___________
When was your last treatment?_______

Have you ever been in a motor vehicle accident, sustained an athletic injury or other trauma? ☐No ☐Yes
Date:________ Reason:______________________________________________________________
Date:________ Reason:______________________________________________________________
Date:________ Reason:______________________________________________________________

Have you ever been hospitalized? ☐ No ☐ Yes Have you ever had surgery? ☐ No ☐ Yes
Date:________ Reason:______________________________________________________________
Date:________ Reason:______________________________________________________________
Date:________ Reason:______________________________________________________________

What is the purpose of your visit: ____________________________________________________
What started this condition: _________________________________________________________
When did this condition begin: _______________________________________________________
What aggravates this condition: ______________________________________________________
What relieves this condition: _________________________________________________________
Have you received treatment from other healthcare providers for this condition? ☐ No ☐ Yes
If yes, who are they and what type of healthcare provider are they:
______________________________________________________________________________
______________________________________________________________________________



**please fill out information on the back**

Please circle current symptomatic areas in your body on the diagrams above.

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**Have you been diagnosed with, or have you ever experienced any of the following?**
If **Yes**, please mark with an "**X**" on the line provided.

**Circulatory/Respiratory**

___ Chronic congestive heart failure
___ Heart disease
___ Other heart condition
___ High blood pressure
___ Low blood pressure
___ Varicose veins
___ Phlebitis
___ Deep vein thrombosis
___ Raynaud's disease/phenomenon
___ Buerger's disease
___ Chronic cough
___ Bronchitis
___ Asthma
___ Emphysema
___ Shortness of breath

**Nervous system**

___ Epilepsy
___ Multiple sclerosis
___ Cerebral palsy
___ Parkinson's
___ Nerve lesion
___ Sciatica
___ Carpal tunnel syndrome

**Musculoskeletal**

___ Scoliosis
___ Bone or joint disease
___ Arthritis
___ Joint instability
___ Tendinitis
___ Fractured bones
___ Jaw pain (TMJ)
___ Whiplash

**Skin**

___ Sensitivities to oils, lotions, detergents
___ Other allergies or hypersensitivities
___ Irritated skin conditions
___ Contagious conditions
___ Frostbite
___ Lack of sensation

**Have you ever suffered from:**

Heart Attack ☐ No ☐ Yes
Date:___________
Stroke ☐ No ☐ Yes
Date:___________

**General**

___ Cancer/Tumours
___ Undiagnosed lump
___ Diabetes
___ Kidney problems
___ Liver problems
___ Drug/Alcohol addiction or withdrawal
___ Infectious conditions (hepatitis, HIV, etc.)
___ Eating disorder
___ Recent abortion or vaginal birth
___ Loss of vision or hearing

**Please list any other condition not listed & provide details as necessary**

_________________________
_________________________
_________________________
_________________________
_________________________
_________________________
_________________________
_________________________

I,____________________ hereby declare that all of the above information is correct, and if it should change, it is my responsibility to notify the therapist of these changes at the next scheduled appointment.

**Signature of Client:**____________________________________________________ **Date:**_____________
**Signature of Parent/Guardian (if applicable):**______________________________ **Date:**_____________