CROSSFIT SQUAMISH/SQUAMISH BARBELL
Massage Therapy Health History

Name:_____ Birthday_____/_____/_____ Todays' date: _____
M D Y

Address:_____

Phone: (best to reach you) _____ Email: _____

Occupation/ Employer:_____

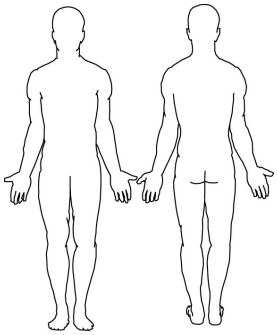
How did you hear about us? ❒ CFSQ Client/Friend _____ ❒ Internet search

❒ Health Care Practitioner_____ ❒ Other _____

---

* Please explain your primary concern(s)?

(and show locations!)



What aggravates it? _____ Relieves it? _____

*Major Illnesses/Surgeries/Accidents	Date
_____	_____
_____	_____
_____	_____

*Current Medications (please list and explain) _____

_____

***HEALTH CARE** you have used **PAST (P)** and **CURRENT (C)** and **practitioner**

RMT: P / C _____ Date of last Massage**:** _____

Physio: P / C _____

Chiro: P / C _____

Naturopath: P / C _____

Acupuncture: P / C _____

Other: P / C _____

…. You're not done quite yet! Please complete the reverse side of this page.

THE FOLLOWING QUESTIONS ARE DESIGNED TO GIVE US A BETTER UNDERSTANDING OF THE VARIOUS INFLUENCES ON YOUR HEALTH & HEALING:

*Please rate (1 to 10 scale- 10 is good/high) your:

NUTRITION : 1 2 3 4 5 6 7 8 9 10 HYDRATION: 1 2 3 4 5 6 7 8 9 10

STRESS: 1 2 3 4 5 6 7 8 9 10 MOTIVATION: 1 2 3 4 5 6 7 8 9 10

SLEEP : 1 2 3 4 5 6 7 8 9 10 -Quality of Sleep: 1 2 3 4 5 6 7 8 9 10

Sleep positions (side, back, stomach) _____ Sleep well? **Y / N** Avg hrs? _____

* Are any of the following a regular part of your life?

Alcohol? **Yes No Sometimes**

Smoke? **Yes No Sometimes**

Coffee? **Yes No Sometimes**

Grains? **Yes No Sometimes**

Dairy? **Yes No Sometimes**

Sugar? **Yes No Sometimes N**

Meat? **Yes No Sometimes**

Pain meds? **Yes No Sometimes**

Please list any other supplements?_____

* Do you get headaches? **Y / N** How often? _____ Location? _____

* Grind your teeth? **Y / N** Wear a mouth guard? **Y / N**

* Do you spend significant time: At a computer? **Y / N** Driving? **Y / N** Sitting? **Y / N**

* Have you given birth? **Y / N** #? _____ Any difficult labours? **Y / N** C- sections? **Y / N**

* Do you have regular bowel movements (ie.daily)? **Y / N**

* EXERCISE: Regular part of your routine? **Y / N** Are you usually sore after exercise? **Y / N**

Do you spend focused time on stretching/mobility? **Y / N**

List regular activities (anything physical counts!) _____

* How willing are you to take an active role in maintaining optimal health? 1 2 3 4 5 6 7 8 9 10

PLEASE LIST ANY OTHER PAST OR CURRENT MEDICAL CONCERNS OR DIANOSES:

_____

YOUR APPOINTMENT time is reserved especially for you and includes time for assessment and homecare. If you need to reschedule or cancel, we require 24 hours notice so we may offer the time to someone else. Cancellations within 24 hrs are subject to the full fee. Thank you for your understanding!

I understand that I am responsible to pay for any appointment I miss, barring emergencies:

Signed:_____ Date:_____