

Arbour Wellness Centre

Chantal David, Colon Therapist & Spa Therapist

2136 Bowen Road, Nanaimo, BC Canada V9S 1H7

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Massage Therapy Intake Form

Name: _____ Date: _____

Address: _____ Postal Code: _____

Home Phone: _____ Business Phone: _____

Email: _____ DOB: _____

Occupation: _____ Referred By: _____

Other Healthcare Practitioners: _____

Medications you now take: _____

Past falls or accidents: _____

Hospitalizations: _____

Do you have any of the following conditions?

Arthritis Allergies (including oils and or/creams) _____

Headaches Chronic pain (where?) _____

Pregnant Due Date: _____

New Mother Nursing

Varicose Veins Flu or Cold Fever

Inflammation Infection Contagious disease

Appliances (Screws, Pacemakers, etc...) _____

Cancer Diabetes Epilepsy/Seizures

High Blood Pressure Low Blood Pressure Skin Problems

Muscle Spasms Stroke Circulatory Problems

Other conditions you feel may affect your treatment: _____

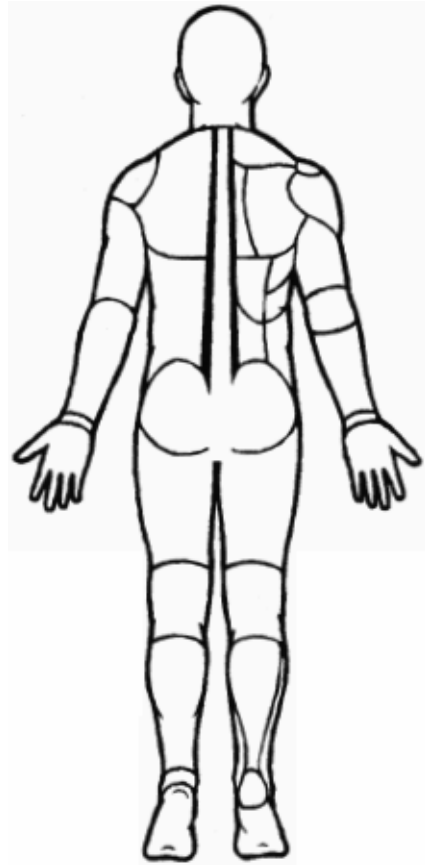
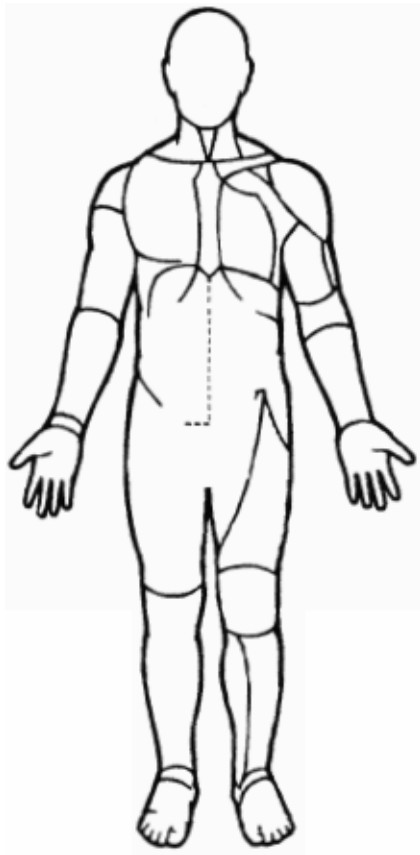
Lifestyle Section

Do you exercise? _____ Yes _____ No. If yes, describe your routine _____

Do you consume the following beverages? _____ coffee _____ colas _____ alcohol
_____ water

How would you describe your eating habits?

What do you hope to achieve through Massage Therapy?



Please indicate areas of pain or discomfort on the diagrams above.

**** Please Read****

I understand that massage therapy is an aid to health but does not take the place of any care my Medical Doctor may recommend. I have given correct information regarding my health and am not aware of any reason for not having massage therapy.

Signature: _____ Date: _____