shanti yogi
WELLNESS CENTRE DE SANTÉ

# *Client information sheet - Massage*

Name: _____ Date of Birth:_____

Address:_____

Telephone: _____ (home) _____ (work) _____ (Cell)

Profession:_____ Physical activity: _____

Right-handed ( ) Left-handed ( )

Name of insurance company:

_____

What are your main health concerns? Any pain?_____

_____

_____

**Check all that apply**

Circulatory ( ) Heart disease ( ) Pacemaker ( ) Glandular ( ) Phlebitis ( ) Epilepsy ( )

Hepatitis B\HIV\AIDS( ) Haemophiliac ( ) Respiratory problems ( ) Allergies ( )

Nervous condition ( ) Arthritis (type) ( )_____

Plantar's warts ( ) Athlete's foot ( ) Varicose veins ( ) Diabetic ( )

Other skin problems: _____

Panic or anxiety attack ( ) Fatigue ( ) Stress ( ) Pregnant ( ) Migraines ( )

Constipation ( ) Diarrhea ( )

Frequent urination ( ) Sleep well? ( ) Anticoagulants ( ) Cortisone ( ) Hormones ( )

Other medications _____

*Blood pressure:* Normal ( ) High ( ) Low ( )

*Thyroid gland:* Hyper ( ) Hypo ( )

*Cholesterol:* High ( ) Normal ( )

Have you ever had cancer in the last four years? What kind?_____

_____

Other serious illness or disease, present or past?

_____

Are you presently being treated by a doctor or other health professional? ( ) If yes, why?_____

Have you had any surgery in the past years? What kind?

_____

Have you had any accidents? ( ) When? _____ Broken bones ( ) What/when?

_____

Do you smoke? ( ) Nutrition/glasses of water per day _____

What kind of natural treatments have you tried?

_____

Anything else you would like to mention about your health?_____

_____

_____

I declare that all personal and medical information provided hereto is accurate. I agree to the treatment given today and understand that this session is not a substitute for medical advice. It is recommended that I see a licensed physician, or licensed health-care professional, for any physical or psychological ailment I have.

Signature: _____ Date: _____

***NOTES :***

_____

_____

_____

_____

_____