pureREVIVAL
Massage Therapy & Wellness

PureRevival
Unit 7&8 6601 44St
Lloydminster Ab, T9V 2X1
(P) 780-875-1803

Client Intake Form

Name:_____
Gender: M ☐ F ☐
Address: _____
_____
Postal Code: _____
Phone: (H) _____
(W)_____
(C)_____

Birthdate:(D/M/Y)_____
Email: _____
Occupation: _____
Family Doctor: _____
Referring Professional:_____

How did you hear about PureREVIVAL:
_____

Please indicate if you believe if any of the following apply to you? (P=Past C= Current) Circle if necessary (if you say Past – please indicate the date or year)

- ☐ Heart Attack
- ☐ High/Low Blood Pressure
- ☐ Stroke or Aneurysm
- ☐ Pace Maker
- ☐ Other Heart Condition
- ☐ Varicose Veins
- ☐ Bruise easily
- ☐ other Circulatory condition _____
- ☐ Diabetes
- ☐ Kidney Disease
- ☐ Other Urinary condition
- ☐ Numbness
- ☐ Bursitis
- ☐ Blood Clots
- ☐ Headaches/Migraines
- ☐ Dizziness/Fainting
- ☐ Nausea
- ☐ Spinal Injury
- ☐ Head Injury
- ☐ Epilepsy/other seizures
- ☐ Other Neurological condition
- ☐ Fibromyalgia
- ☐ Asthma
- ☐ Chronic Sinusitis
- ☐ Other Respiratory condition
- ☐ Irritable Bowel/Colitis
- ☐ Digestive condition
- ☐ Skin condition
- ☐ Joint Dislocation
- ☐ Bone Fracture
  If so location:_____
- ☐ Arthritis
- ☐ Osteoporosis
- ☐ Rods/Pins/Plates/Shunts
- ☐ Implants
- ☐ Transplants_____
  Corrective Lenses/Contacts
- ☐ Cancer_____
- ☐ Hepatitis
- ☐ HIV
- ☐ Other Contagious condition _____

Are you Pregnant? ☐ **Yes** ☐ **No** **If Yes - Due Date:** _____
Are you currently breast feeding? ☐ **Yes** ☐ **No**
Do you know of any complications during your birth? Were there any complications if you have given birth? _____
_____

Please list any Medications you presently take:
_____
_____
_____

Known Allergies (including medications, foods, seasonal, oils and lotions, etc.)
_____

Do you have any current/past history of medical conditions? : ☐ **Yes** ☐ **No**
Please list: _____

Have you ever been hospitalized, had any major accidents, illnesses, or surgeries? :
☐ **Yes** ☐ **No**
Please comment: _____

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Other therapy /treatment: (past or present, does not have to be related to this visit)

		Date of Last Visit:	Location:
☐	Massage Therapy	_____	_____
☐	Chiropractor	" _____	" _____
☐	Physiotherapy	" _____	" _____
☐	Naturopath	" _____	" _____
☐	Acupuncture	" _____	" _____
☐	Osteopath	" _____	" _____
☐	Other_____	" _____	" _____

List any Activities, Sports, Hobbies
(ex. Jogging, Hockey, Crafts, Computers, etc.)

_____
_____
_____

List any **NON-prescription vitamins, minerals or other supplements** you are taking:

_____
_____
_____

Please CIRCLE the answer closest to how you <u>PRESENTLY</u> feel: (1=poor, 5=excellent)

Quality of Sleep	1	2	3	4	5	Hours of sleep per night (approx.) _____
Energy Level	1	2	3	4	5	
Eating Habits	1	2	3	4	5	Number of meals you regularly eat per day _____
Exercise Habits	1	2	3	4	5	
Stress Level	Low				High	Number of times you exercise per week _____

<u>Smoker:</u> Yes No Occasional <u>Alcohol:</u> Yes No Occasional

Current Condition:

Please describe your current condition & symptoms:

_____
_____
_____
_____
_____

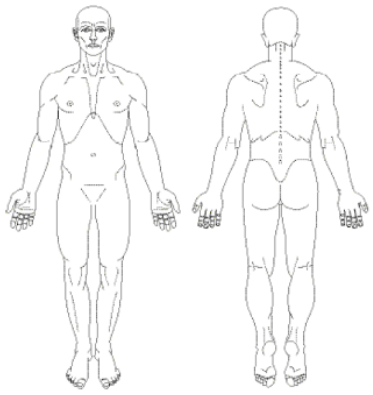
How long have you had this condition? _____

How did it start? _____

What aggravates it? _____

What relieves it? _____

Please indicate on the diagram the nature of your symptoms, using the symbols indicated:



Aching	O O
Stabbing	X X
Shooting	➔
Burning	# #
Numbness or Tingling	~~

Please Note: Your appointment time has been reserved for you. In courtesy of your therapists & fellow patients, we ask that you provide us with 24 hours notice of cancellation, or a cancellation fee will be charged. Payment for all treatment, whether private or insured, is ultimately the responsibility of the patient.

I authorize the clinic and its associated therapists to collect my personal and medical information as documented above in order to contact me, and give permission for the clinic to leave messages regarding appointments at any of the contact number I have provided above. In addition, I authorize the clinic and its associated therapists to communicate with my referring MD as deemed necessary for my beneficial treatment. I also understand that my personal and medical information is confidential and will only be disclosed to third parties with my permission.

Signature: _____ **Date:** _____

Signature of Consents from Parent or Legal Guardian: _____
Required if applicant is under 18 years of age