Name: ______________________________ Date: ______________

Address: ____

City, Province: ______________________________ Postal Code: __________

Phone-Residence: ____________________ Business: ____________________

Cell: ____________________ Email: ______________________________

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Would you like on-line booking [ ]Yes [ ]No Also, receive our email newsletter [ ]Yes [ ]No

D.O.B (YYYY/MM/DD) ____________ Occupation: ____________________

How did you hear about Fruition? [ ]Friend____________[ ]MD [ ]Internet [ ]Yellow pages

Past falls or accidents: ______________________________________

Hospitalizations : ______________________________________

Medications you now take: ______________________________________

Is your visit a result of? A recent car accident? [ ]Yes [ ]No A work related injury? [ ]Yes [ ]No

HEALTH INFORMATION:

Please indicate if you have had any of the following:

[ ] Appendicitis
[ ] Scarlet Fever
[ ] Diphtheria
[ ] Typhoid Fever
[ ] Pneumonia
[ ] Rheumatic fever
[ ] Polio
[ ] Malaria
[ ] Tuberculosis
[ ] Whooping Cough
[ ] Anemia
[ ] Measles
[ ] Mumps
[ ] Small Pox
[ ] Chicken Pox
[ ] Diabetes
[ ] Cancer
[ ] Heart Disease
[ ] Goiter
[ ] Influenza
[ ] Pleurisy
[ ] Alcoholism
[ ] Venereal Infection
[ ] Arthritis
[ ] Epilepsy
[ ] Mental Disorder
[ ] Eczema
[ ] Hemophilia

Have you had any of the complaints listed below in the last year?

GENERAL
[ ] Dental Problems
[ ] Loss of Sleep
[ ] Fever
[ ] Headaches
[ ] Migraines
[ ] Allergies
Please list:
____
____

MUSCULOSKELETAL
[ ] Low Back Pain
[ ] Pain Between Shoulders
[ ] Arthritis
[ ] Neck Pain
[ ] Scoliosis
[ ] Arm Pain
[ ] Joint Pain/Stiffness
[ ] Walking Problems
[ ] Difficult Chewing/Clicking Jaw
[ ] Bruise Easily

NERVOUS SYSTEM
[ ] Numbness
[ ] Convulsions
[ ] Cold/ Tingling Extremities
[ ] Forgetfulness
[ ] Fainting
[ ] Paralysis
[ ] Dizziness

CVR
[ ] Chest Pain
[ ] Short Breath
[ ] Blood Pressure Problems
[ ] Irregular Heart Beat
[ ] Heart Problems
[ ] Lung Problems/ Congestion
[ ] Varicose Veins
[ ] Ankle Swelling
[ ] Stroke

FEMALES ONLY
Are you Pregnant? [ ] Yes [ ] No [ ] Maybe
[ ] Breast Pain/ Lumps
[ ] New Mother
[ ] Nursing

Gestation Week : ____________________

Due Date: ____________________

What are your intentions for this session or the reason you are here today?

____

Please describe any specific health conditions or challenges that you are currently experiencing and the treatments that you are following for these conditions (i.e. health practitioner, chiropractic care, physiotherapy, acupuncture, supplements, diet, exercise, bodywork, etc).

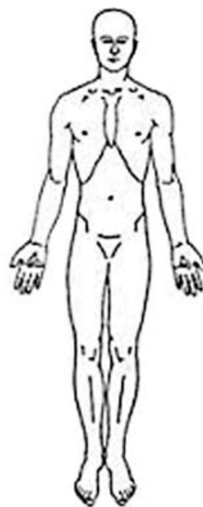
____

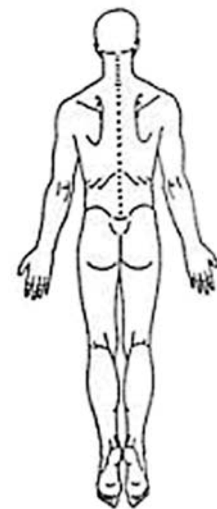
____

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

Please add any additional information that will assist us to work with you effectively.

____





It is my choice, as a client, to receive treatment at Fruition Therapeutics. If I experience any pain or discomfort during my session, I will immediately inform the practitioner so that pressure or strokes may be adjusted to my level of comfort.

I understand that massage therapists do not diagnose illness, disease or any other physical or mental disorder; nor do they prescribe medical treatment of any kind. I acknowledge that massage is not a substitute for medical examination, diagnosis or treatment, and that it is recommended that I see a physician for these services.

I understand that massage therapists are not qualified to perform spinal or skeletal adjustments, diagnose, prescribe, or treat any physical or mental illness, and that nothing said in the course of a session should be considered as such.

Because massage/bodywork should not be performed under certain medical conditions, I affirm that I have stated all my known medical conditions and have answered all questions honestly. I agree to take it upon myself to keep the massage therapist updated on my health and well being and I understand that there shall be no liability on the practitioner's part should I fail to do so.

I also understand that any illicit or sexually suggestive remarks or advances made by me will result in immediate termination of the massage, and I will be liable for payment for the full time scheduled.

I understand that I am responsible for paying a 50% service fee charge for any appointment cancellation with less than 24 hours' notice, a full service fee charge will be applied to a missed appointment and that late arrivals are responsible for the fee of the entire session.

Signature: ______________________________ Date: ____________________