Trikinetic Massage Therapy

#302 – 1750 E 10th Avenue, Vancouver BC V5N 5K4 604-879-9400

Legal Name: ________________________________

Preferred Name (if different): ________________

Pronoun:________________________________

Email:________________________________

I would like to receive email updates: ☐ Yes ☐ No

Phone: (Home) ____________________________

(Cell) ____________________________

(Work) ____________________________

Address: ________________________________

____

Postal Code: ____________________________

Reminder Method__________________________

Birthdate: ________________________________

m/d/y

Occupation: ______________________________

Family Doctor: ____________________________

Phone:____________________________

Referring Professional:______________________

Phone: ____________________________

EHB Plan Number: _________________________

Individual ID #______________________________

Care Card # ______________________________

Do you have an active ICBC claim? ☐ Yes ☐ No

If yes, claim # ______________________________

(You will need to fill out the related MVA form)

How did you hear about Trikinetic Massage? ____

Current Condition

Please describe your current condition and

symptoms:________________________________

____

____

How long have you had this condition?

____

How did it start?

____

What aggravates it?__________________________

____

What relieves it?____________________________

____

Is there another issue/concern that brought you here

today? ____________________________

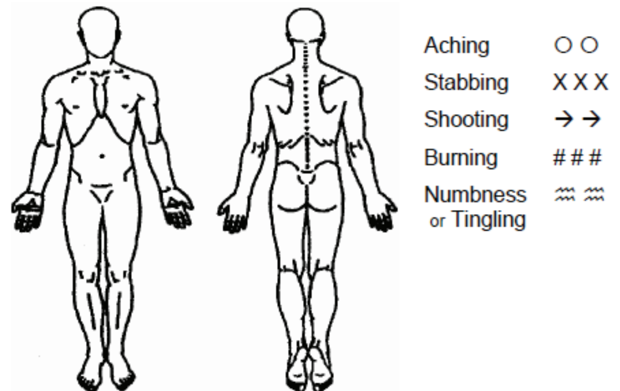
Known allergies: (including medications, foods, seasonal, oils, lotions, foods, etc.)

____

____

____

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



Please list any medications you presently take:

____

____

Have you ever had any major accidents, illnesses or surgeries? If yes, have you been hospitalized for it?

☐ Yes ☐ No

Please comment, including dates: ____

____

Other Medical Therapies

Have you had any other type of Medical Therapy? (chiropractic, physiotherapy, acupuncture, other)

____

Was this useful? ______________________________

____

Was there anything you didn't find useful?

____

Please CIRCLE the answer closest to how you presently feel: (1 = poor, 5 = excellent)

Quality of Sleep	1	2	3	4	5
Energy level	1	2	3	4	5
Eating Habits	1	2	3	4	5
Exercise Habits	1	2	3	4	5

Hours of sleep per night (approx.) _______

Number of meals you regularly eat per day ____

Smoker	Yes	No	Occasional
Alcohol	Yes	No	Occasional

Indicate if you believe any of the following apply to you (P = past C = current) Circle if necessary.

__ Heart Attack
__ High / Low blood pressure
__ Stroke or Aneurysm
__ Other Heart Condition:
____
__ Varicose Veins
__ Other circulatory condition:
____
__ Diabetes
__ Kidney Disease
__ Other Urinary condition:
____
__ Headaches
__ Dizziness / Fainting
__ Spinal / Head Injury
__ Epilepsy / Seizures

__ Other Neurological Condition:
____
__ Asthma
__ Other Respiratory Condition
____
__ Irritable Bowel / Colitis
__ Skin Condition:
____
__ Joint Dislocation
__ Bone Fracture
__ Arthritis
__ Osteoporosis
__ Rods / Pins / Plates / Shunts
__ Cancer: ________________
__ Hepatitis / HIV
__ Other Contagious Condition

__ Insomnia
__ Depression
__ Anxiety
__ Other Mental Health Concern:
____
__ Fibroids / Cysts
____
__ Painful / Heavy Bleeding
__ Pregnancy; Years:
____
__ Cesarean? Year (s): ________
__ Peri / Menopause
__ Prostate Condition:
____

____

Please Note: Your appointment time has been reserved for you. As a courtesy to your therapist & fellow patients, we ask that you provide us with 24 hours notice of a cancellation or change of appointment, or you will be charged for the full amount of the appointment. In the event you are late for an appointment, we will not provide supplementary time. Payment for all treatment is ultimately the responsibility of the patient.

Signature: ________________________ Date: ________________________