evolve
THERAPEUTIC MASSAGE INC.

First Name: _____ Last Name: _____ DOB: D: ____ M: _____ Y: _____

Address: _____ City: _____ Postal Code: _____

Phone (Mobile): _____ (Home): _____ (Work): _____

Emergency Contact: _____ Phone: _____

Occupation: _____ E-mail: _____

Describe your current concern: _____

What makes the concern better? _____

What makes the concern worse? _____

Please list all medications: _____

Please list all surgeries, illnesses, and accidents: _____

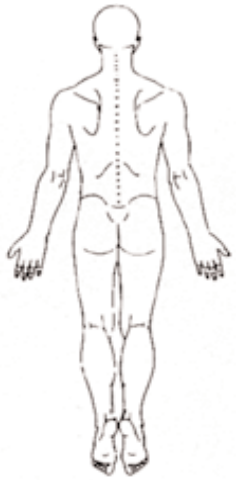
Please list all therapy you have had for the concern: _____

Do you have an active ICBC claim? If so, please provide claim #: _____

History (check all that apply):

□ Arthritis	□ Headaches/Migraines	□ Pregnancy
□ Asthma	□ Head or Spinal Injury	□ Respiratory Condition
□ Cancer	□ Heart Condition	□ Seizures
□ Contagious Condition	□ High/Low Blood Press.	□ Skin Condition
□ COPD	□ Insomnia	□ Sprains/Strains
□ Diabetes	□ Jaw Pain/TMJ	□ Stroke
□ Digestive Condition	□ Kidney Condition	□ Surgery
□ Fainting	□ Mental Stress	□ Tinnitus/Vertigo
□ Fractures/Dislocations	□ Nausea/Vomiting	□ Varicose Veins

Please indicate areas of pain



MISSED APOINTMENTS INITIAL _____

Please note: We require 24 business hour notice if you are unable to keep your appointment.
This is so we may book another appointment in its place.
There will be a service charge for any missed appointment without the required 24 hours' notice.

Signature: _____ Date: _____

OFFICE USE

ICBC No.: _____ Date of MVA: DD:_____ MM:_____ YYYY: _____

Adjuster's Name: _____ Phone No.: _____

Lawyer's Name: _____ Phone No.: _____