Isabelle Lafontaine
Massage Therapist
91 Laval Street, Gatineau, QC, J8X 3H4
Tel: (819) 771-8700 • Fax: (819) 771-8683

Health Questionnaire

❑ Male ❑ Female Last Name: ______________________________ First Name: ______________________

Address: ____

Town: ____ Postal Code: __________________

Tel. Home: ______-______-______ • Work: ______-______-______ • Cell: ______-______-______

Date of Birth: ( ) Day ( ) Month ( ) Year Occupation: ____________________________________

E-mail: ____

❑ Yes, you may send me appointment reminders and my statements via e-mail. ❑ No, do not contact me by e-mail.

How did you hear about us: ____

Date of first appointment: ( ) Day ( ) Month ( ) Year Insurance? ❑ Yes ❑ No
Company: ___________________

Reason for consultation: ____

____

Have you ever seen a doctor about this? ❑ Yes ❑ No

Have you ever seen a therapist? ❑ Yes ❑ No If yes, which one? ______________________________
(Ex: physiotherapist, chiropractor, other)

What are your expectations? ____

____

Women only: Are you pregnant? ❑ Yes ❑ No Do you have a high risk pregnancy? ❑ Yes ❑ No

Expected date of delivery: _____/_____/_____ (yyyy/mm/dd)

Are your menstruation ❑ regular ❑ irregular • Are you menopausal? ❑ Yes ❑ No

If so, what are your symptoms? ____

____

Do you suffer from digestive problems, diabetes or other diseases? ❑ Yes ❑ No If yes, precise.

____

Do you take medications? ❑ Yes ❑ No If so, which one? ____

____

Do you have allergies? ❑ Yes ❑ No If yes, please list ____

Do you have headaches? ❑ Yes ❑ No

Have you ever had:

Surgeries? ❑ Yes ❑ No If yes, please list: ____

An accident? ❑ Yes ❑ No

Other: ____

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Are you presently suffering from cardiovascular problems? ❑ Yes ❑ No

❑ Hypertension? ❑ Low Pressure? ❑ Angina? ❑ Migraine?

Heart problems? ❑ Yes ❑ No

❑ Palpitations ❑ Infarcts ❑ Stroke If so, when? ____

Vasvcular problems? ❑ Yes ❑ No

❑ Varicose veins ❑ Phlebitis If yes, where and when? ____

Do you wear orthotics? ❑ Yes ❑ No ❑ Contact lenses? ❑ Prostheses? ❑ Other? ______________

How would you rate your diet?

❑ Excellent
❑ Good
❑ Fair
❑ To be monitored

What exercises do you do? How often?

____

____

____

The customer or client, by his signature certifies that the information and other information provided in this customer record are true and genuine. I also certify that I have advised, hereby, the therapist of any problem that could come in between my care
Client's signature: ____ Date: ______________________

In the diagrams below, circle the sore spots and indicate your stress points.