

**CONFIDENTIAL  
CLIENT HISTORY  
FORM**

**Therapist** \_\_\_\_\_

**Date** \_\_\_\_\_

103-853 Richards St, Vancouver, BC. V6B 3B4 Tel: 604.630.3808

**Name** \_\_\_\_\_  
first last

**Date of Birth** \_\_\_\_\_  
day month year

**Address** \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Occupation** \_\_\_\_\_

**Email** \_\_\_\_\_  
Email Special Offers/Join-mailing list?

**CellPhone** \_\_\_\_\_

Have you received professional massage before? \_\_\_\_\_

**Phone** \_\_\_\_\_

How often do you receive a massage? \_\_\_\_\_

**Emergency Contact Name** \_\_\_\_\_  
**Emergency Phone** \_\_\_\_\_

How did you hear about us? \_\_\_\_\_

**Please indicate if you believe any of the following apply to you?**

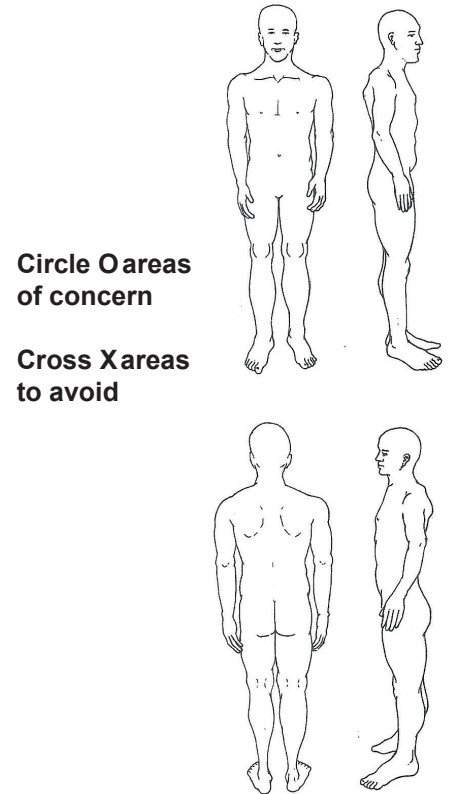
- |  |                                 |
|--|---------------------------------|
| Heart Condition                          | Headaches / Migraines           |
| High / Low Blood Pressure                | Dizziness / Fainting            |
| Deep Vein Thrombosis                     | Neurological Disorders          |
| Stroke                                   | Epilepsy / other seizures       |
| Hepatitis                                | Pregnant ( <i>weeks</i> ) _____ |
| Kidney Disorder                          | Spinal Injury                   |
| Liver Conditions                         | Head Injury                     |
| Sprains or Fractures                     | Respiratory Condition           |
| Artificial Joints                        | Diabetes                        |
| Implants/Shunts/Pacemaker                | Osteoporosis                    |
| Bruise easily                            | Cancer                          |
| Skin Conditions - <i>please explain:</i> |                                 |
| Cuts/Wounds _____                        |                                 |

**Other health related conditions:** \_\_\_\_\_

**Have you had any accidents or surgery?** (if yes, please explain)  
\_\_\_\_\_

**Known Allergies** (e.g. oils and lotions, essential oils, foods)  
\_\_\_\_\_

**Do you have any goals for this treatment?** (e.g. relaxation, improve flexibility)  
\_\_\_\_\_



**Please Note:** Your appointment time has been reserved for you. In courtesy to your therapist & fellow clients, we ask that you provide us with 24 hours notice of cancellation, or a cancellation fee will be charged. Payment for all treatments, is the responsibility of the client.

I authorize Smile Thai Wellness and its associated therapists to collect my personal information as documented above in order to contact me, and give permission for us to leave messages regarding appointments at any of the contact numbers I have provided above.  
I understand that my personal information is confidential and will only be disclosed to third parties with my permission.

I understand Smile Thai Wellness is a multidisciplinary centre and therapists may consult each other in order to give me the most appropriate treatment.  
I have read and understand the additional information on the back of this form about my treatment.  
Sexual harassment is not tolerated. If the safety of the practitioner feels compromised, the session is ended immediately.

**I have stated all known medical conditions and will keep the therapist updated so they can provide the best treatment.**

**Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_