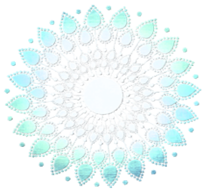

PURE Health Massage & Wellness
#220 - 12565 88th Avenue, Surrey, BC V3W 3J7
Tel: 778-592-1442

ADULT PATIENT PROFILE

DATE_________________________________

FULL NAME ______________________________ AGE ______ BIRTHDATE _____/______/______ MTH/DY/YR

ADDRESS ______________________________ PC ____________________

EMAIL ______________________________ How did you hear about us? ____________________

HOME PHONE # ______________________________ WORK PHONE # ____________________

CELL PHONE # ______________________________ PREFERRED CONTACT: HOME/WORK/CELL

OCCUPATION ______________________________ EMPLOYER ____________________

EMERGENCY CONTACT ______________________________ PHONE ____________________

PRIMARY PHYSICIAN ______________________________ PHONE ____________________

KNOWN ALLERGIES (FOOD, DRUGS, VACCINES, ENVIRONMENTAL ETC.

Note to patients: Please complete this two-sided questionnaire as thoroughly as possible in order to aid the physician in her diagnosis and treatment. This is a confidential record and will NOT be released unless you have authorized us to do so. Thank you

PRESENT HEALTH PROBLEMS CONCERNS: Please list in the order or priority to YOU

1.
2.
3.
4.
5.

LIST OF MEDICATIONS CURRENTLY TAKING (prescription & over the counter drugs, vitamins, herbs, homeopathic remedies etc.

1.	dosage	5.	
2.	dosage	6.	
3.	dosage	7.	
4.	dosage	8.	

PAST MEDICAL HISTORY

Hospitalization (when, for what, and for how long?)

ACCIDENTS & INJURIES

PHYCHIATRIC ILLNESSES

LAST COMPLETE PHYSICAL EXAM DATE:

DESCRIBE ANY ABNORMAL FINDINGS: WERE THE RESULTS ___NORMAL ___ABNORMAL

LAST PAP SMEAR (WOMEN ONLY) DATE: WERE THE RESULTS ___NORMAL ___ABNORMAL

DO YOU DO MONTHLY SELF EXAM? YES __________ NO __________

PERSONAL LIFESTYLE (CHECK AND FILL IN WHERE APPLICABLE)

HABITS:

TOBACCO YES _____ NO _____ HOW MANY YEARS? ______ HOW MANY CIGARETTES PER DAY? ______

CAFFEINE (COFFEE, TEA, POP) YES _____ NO _____ HOW MUCH DAILY? ____________________________

ALCOHOL YES _____ NO _____ HOW MUCH? __________________________

RECREATIONAL DRUGS YES _____ NO _____ WHAT KIND? ___________________ HOW MUCH? ___________________

REGULAR EXERCISE YES _____ NO _____ WHAT KIND? ____________________ HOW OFTEN? ___________________

DIET: DESCRIBE YOUR AVERAGE DAILY MEALS

BREAKFAST:

LUNCH:

DINNER:

SNACKS:

LIST FOODS THAT YOUR CRAVE:

ARE THERE ANY DIET RESTRICTIONS OR REGIMENS THAT YOU RFOLLOW? PLEASE DESCRIBE:

SLEEP

AVERAGE HOURS OF SLEEP PER NIGHT DO YOU TAKE HERBS OR PILLS TO HELP YOU SLEEP? YES ____ NO____

DO YOU HAVE DIFFICULTY SLEEPING? DAILY _____ OFTEN _____ SOMETIMES _____ NEVER _____

DO YOU DREAM? DAILY _____ OFTEN _____ SOMETIMES _____ NEVER _____

SOCIAL HISTORY

MARITAL STATUS SINGLE _____ MARRIED _____ SIGNIFICANT OTHER/COMMON LAW _____ WIDOWED _____

SEXUALLY ACTIVE YES _____ NO _____ TYPE OF BIRTH CONTROL __________________________

HOW MANY CHILDREN? _____ AGES ____

FAMILY HISTORY: CHECK AND FILL IN APPLICABLE BOXES (BLOOD RELATIVES)

	WHO	COMMENTS
ALLERGIES		
ANEMIA		
ARTHRITIS		
AUTO IMMUNE		
ASTHMA		
CANCER		
DIABETES		
EPILEPSY		
HEART DISEASE		
HEPATITIS		
HIGH BLOOD PRESSURE		
KIDNERY DISEASE		
MENTAL ILLNESS		
STROKE		
TUBERCULOSIS		
OTHER		