As accurate health history is important to ensure that it is safe for you to receive massage treatment. If your health status changes in the future please let us know. All the information gathered for this treatment is confidential except as required or allowed by law or except to facilitate diagnosis or treatment. You will be asked to provide written authorization for release of any information.

MASSAGE THERAPY INTAKE FORM

Patients #:_____ Date: _____

Personal history

Name:_____
FIRST INTIAL LAST

Address:_____
Street Apt. City Prov. Postal code

Home ph (___) _____Cell (___) _____Bus. Phone (___) _____

Email _____Would you like to receive newsletters and updates via email Y or N

Birthdate:(dd/mm/yyyy) _____Age: _____ Sex: M F Massage experience:Y N

Business /Employer _____Extended Health Coverage: Y N AMT: _____

Type of Work:_____Circle one: Married Single Divorced Separated Other

Name and number of emergency contact:_____

Referred to us by? : _____

Current Health Condition:

What is your primary complaint?:_____

Other Health Professional seen for this condition: Y N Who? _____

What is your general health status? _____

Please check the conditions that you are currently experiencing, or have experienced often in the past

Head/Neck
Headaches
type:_____
vision problems
contact lenses
earaches

Skin
Skin conditions
type:_____
bruise easily

Medical Doctor
Name: _____
Phone: _____
Date of last visit _____

Respitory
chronic cough
shortness of breath
smoking
breathing problems
type:

Cardiovascular
high blood pressure
low blood pressure
poor circulation
heart disease
phlebitis
stroke
varicose veins

Other conditions
difficult digestion
constipation
liver
gall bladder
kidney
bladder
diabetes-onset
sinus
allergies
insomnia
cancer
arthritis
Dr. diagnosed Y N
affected areas _____

Current Medications
Name for what condition
_____
_____

Other Healthcare
Chiropractic
Physiotherapy
Psychotherapy
Regular Exercise
Massage

Muscle(pain/stiffness)
Neck
Low back
Mid back
Upper back
Shoulder
Leg L/R
Knee L/R

Surgery
type:_____Date:_____
current symptoms: _____

Infections
herpes
hepatitis
plantar warts
TB
Hiv, Aids
Other:_____

Women
menstrual problems/painful
caesarian section or other
gynecological surgery
_____
pregnant: due date:_____
children: number _____

Injury
type: _____
date: _____
current symptoms: _____

Other medical conditions? _____
Of special note: (pins,wires,artificial joints
Or limbs) _____