General Information - Massage Intake Form

Name:_____ Gender: M / F

Address:_____

City:_____ Province:_____ Postal Code: _____

Tel. Number:_____ Email address:_____

Date of Birth:_____ Occupation:_____

Primary Health Care Physician:_____

Address:_____ Tel. Number:_____

Emergency Contact Person:_____ Tel. Number:_____

Are you currently seeking other therapies (Chiro, Physio, etc)?_____

Why are you seeking Massage Therapy?_____

Privacy Policy

Your knowledge and consent are required before the collection, use, or disclosure of your personal information. All information gathered will only be used for treatment purposes. Unless required legally or in case of medical emergency, all collected information will be kept confidential. Written authorization will be required for release of any information.

Client Consent

I understand that all massage treatments will be discussed and planned with the Massage Therapist, and will require my informed consent before treatment begins. I am aware that it is not necessary to remove all articles of clothing for treatment, and that I can remove only the clothing that I am comfortable with. I will give consent for the treatment of those body parts for which I give permission. I will communicate with my Massage Therapist at any time I feel my well being is being compromised or uncomfortable. I am aware that I may terminate treatment at any point during the massage at my discretion and without reason. I am aware that I may experience possible side effects from the treatment, such as: bruising, temporary dizziness, light-headedness, temporary discomfort within muscle (up to 48 hours post treatment)

Cancellation Policy

All appointments must be cancelled and rebooked prior to 24 hours before the scheduled appointment time.

Signature of Patient: _____

Date: _____

Health Information:

Soft Tissue/Joints:
Please specify nature: pain, stiffness, numbness, tingling, burning, achy, etc.
[ ] neck _____
[ ] shoulder _____
[ ] back _____
[ ] arms _____
[ ] legs _____
[ ] knees _____
[ ] hips _____
[ ] chest _____
[ ] other _____

Headache:
[ ] tension
[ ] migraines
[ ] sinus
[ ] head trauma/concussion
[ ] other, please specify:
_____
_____
_____

Accidents/Injury/Trauma (physical or emotional)
Type: _____
Date: _____
Symptoms:
_____
_____
_____
_____

Physical Limitations:
_____
_____
_____
_____

Respiratory:
[ ] shortness of breath
[ ] bronchitis
[ ] asthma
[ ] emphysema
[ ] pneumonia
[ ] sinus issues
[ ] other: _____

Cardiovascular:
[ ] high blood pressure
[ ] low blood pressure
[ ] phlebitis/deep vein thrombosis
[ ] pulmonary emboli
[ ] pacemaker
[ ] angina
[ ] chronic congestive heart failure
[ ] heart attack, date: _____
[ ] stroke/cva date: _____
[ ] other:_____

Infectious Disease:
[ ] hepatitis
[ ] infectious skin disease
[ ] tuberculosis
[ ] HIV
[ ] other: _____

Gastrointestinal:
[ ] irritable bowel syndrome
[ ] crohn's disease
[ ] colitis
[ ] constipation
[ ] other: _____

Skin and Hair:
[ ] bruise easily
[ ] herpes
[ ] varicose veins
[ ] loss of sensation
[ ] fungal infection
[ ] other:_____

Other Conditions:
[ ] epilepsy
[ ] diabetes, onset: _____
[ ] cancer: _____
[ ] arthritis: _____
[ ] vision loss
[ ] hearing loss
[ ] osteoporosis/osteopenia
[ ] vertigo
[ ] fibromyalgia/CFS
[ ] mental illness: _____
[ ] neurological: _____
[ ] gynecological:_____
[ ] Smoker
[ ] Allergies: _____
[ ] other: _____

Current medications or supplements:
_____
_____
_____

Surgery:
Type: _____
Date: _____
Current symptoms, pins, wires, complications:
_____
_____

I have read the above information and stated all previous and current medical conditions to the best of my knowledge. I agree to disclose any changes in my condition, and will update the form annually.

Signature:_____ Date:_____