Massage Therapy Intake Form

Date _____

PERSONAL INFORMATION

Name _____ / _____ / _____
last first middle initial

Personal Health # _____ - _____ Male Female

Home Address _____ City _____

Postal Code _____ Email Address (optional)_____

Phone #'s: Home _____ Cell _____ Bus _____

Birth Date _____ /_____ /_____ Height: _____ Weight: _____ Marital Status M S W D
Y M D

Family Doctor (G.P)_____
Name Location Phone Number

Please be advised that in the interest of inter-professional communication, we will be in touch with your physician regarding the care you receive at our clinic.

Occupation: _____

Emergency Contact_____
Name Phone Number Relationship

Whom can we thank for your referral? We would like to send them a token of our appreciation. _____

Is this a workplace injury? Yes / No *Please be advised that we do not accept WCB cases.

Is your injury the result of a motor vehicle accident? Yes / No. If yes, additional intake forms are required.

The healthcare team in this clinic meets regularly to discuss interdisciplinary co-treatment of our patients. If you **do not** wish us to discuss your case, please initial here: _____

Missed office Visits:
A charge of $62 will be made in the event of a missed office visit, or if less than 24 hours' notice is given when canceling an appointment.

Late Policy:
In the event that you are late for your appointment, you will be billed for the entire duration that was scheduled

Attire / Hygiene: Some treatments require direct skin contact, please bathe before attending your appointment and refrain from wearing any scented perfumes and lotions.

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HEALTH INFORMATION

1. Was there an incident that brought on your current problem/injury?

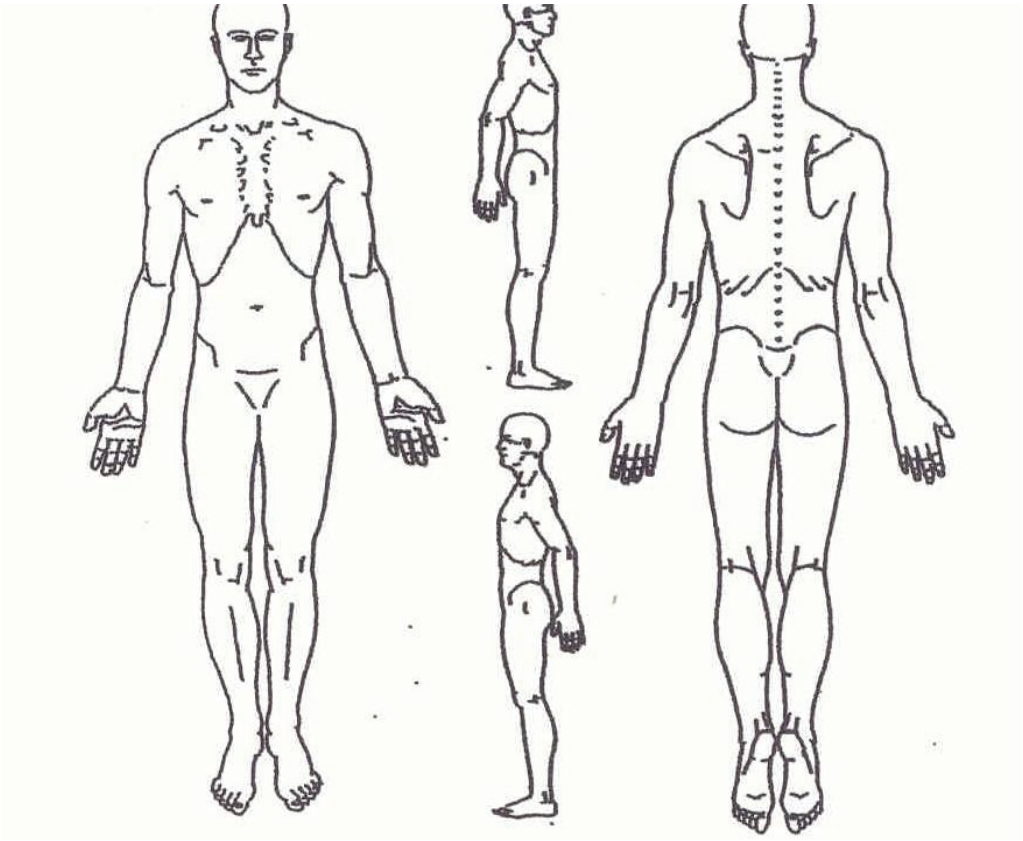
   Yes, please describe _____

   No

2. For how long have you been experiencing this problem? _____

3. Mark the areas on the body drawings where you feel the following sensations using their corresponding symbols. Please include **ALL** affected areas

Sensation:	Ache	Numbness	Pin & Needles	Burning	Stabbing
	\\\\\\\\	++++++	ooooooo	bbbbb	ssssss
	\\\\\\\\	++++++	ooooooo	bbbbb	ssssss



4. What is your current occupation? _____

5. Does your current occupation require any of the following continuous postures? (Please check all that apply)
   - Seated
   - Standing
   - Bent forward
   - Bent backward
   - Other _____

6. What kinds of sports are you involved in? _____

7. What other kinds of activities/hobbies are you involved in? _____

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8. If you have been treated for any of the following conditions please indicate with a check mark:

MUSCULOSKELETAL
- Fracture, where? _____
- Sprain/Strain
- Joint Replacement
- Whiplash
- Gout, where? _____
- Arthritis (OA, RA)

SKIN
- Eczema/Dermititis
- Psoriasis
- Fungal Infection
- Other _____

NERVOUS SYSTEM
- Fainting/Dizziness
- Seizures/Epilepsy
- Neurological Disorder

GASTROINTESTINAL SYSTEM
- Hemorrhoids
- Abdominal Pain
- Digestive Problems
- IBS

CARDIOVASCULAR SYSTEM
- Heart Disease
- Blood Pressure
  - High / Low
- Blood Clots
- Circulatory Issues
- Varicose Veins

RESPIRATORY SYSTEM
- Emphysema
- Bronchitis
- Asthma
- Pneumonia

OTHER
- Kidney Disorder
- Liver Disorder
- Thyroid Problems
- Tuberculosis
- Diabetes
  - Type I / Type II
- Cancer
- Anemia
- Hemophilia
- HIV/AIDS
- Hepatitis
- Headaches/Migraines
- Depression
- Anxiety

9. Are you pregnant?

   Yes, how many weeks? _____

   No

10. Are you currently on any medications?

    Yes

    Please list: _____

    Symptoms/Indications: _____

    No

11. Have you had any other previous conditions, not listed above, that you think your therapist should be aware of?

    _____

    _____

12. Please list all surgeries you have had in the last 5 years:

    _____

    _____

    _____

13. Do you have any other information that would be beneficial to **YOUR** treatment?

    _____

    _____

    _____

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The information that I have provided is accurate to the best of my knowledge. I understand that due to the nature of the treatment I am **REQUIRED** to notify the therapist and my family physician of any contagious and/or communicable diseases

Name (Print): _____ Signature: _____ Date: _____

RMT: _____

INFORMED CONSENT TO TREATMENT

I, (please print) _____ understand that massage therapy given at Urgent Care Chiropractic Clinic is for the purpose of soft tissue injury relief.

I also understand that the therapist does not diagnose any physical or mental disorders and as such will not prescribe medical treatments not perform any chiropractic adjustments.

It has been made clear to me that massage therapy is not a substitute for medical or dental examinations and/or diagnosis and that it is recommended that I see a physician for any ailment that I might have.

Because the massage therapist must be aware of any pre-existing conditions, I have disclosed all of my known medical history and take it upon myself to keep this information current and to update the therapist of any changes.

Signature _____

Date _____

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