Thank you for choosing us for your therapy! Please fill out this intake form as thoroughly as possible. Feel free to ask any questions about any information being requested. All information gathered for this treatment is confidential. Email addresses are only used for appointment confirmations, reminders, cancellations, and occasional clinic news. Your written permission will be required to release any information.

PATIENT INFORMATION

Full Name: ______________________________ Birth Date (MM/DD/YY): ___ /___ /___ M/F

Address: ______________________________ City: __________________ Postal Code: _______

Tel (Home): ______________ (Cell): ______________ (Work): __________________

Email: ____________________________ Occupation: ____________________________

Emergency Contact Name: ______________ Phone: ____________________________

Medical Doctor (Name & #): __________________________ If needed, may we contact them? Y/N

How did you hear about us?

- ☐ Friend:______________
- ☐ Family Member: ___________
- ☐ Website: _______________
- ☐ Doctor: ________________
- ☐ Ad: ___________________
- ☐ Other: ________________

Primary reason for receiving massage therapy? ______________________________________

General Health Status? ____

What other treatment have you tried (previously or current):

- ☐ Chiropractic
- ☐ Acupuncture
- ☐ Physiotherapy
- ☐ Naturopath
- ☐ Massage
- ☐ Other:_________________

CURENT HEALTH HISTORY

Health History: please indicate condition you are experiencing or have experience):

- ☐ Chronic Cough
- ☐ Shortness of Breath
- ☐ Bronchitis
- ☐ Asthma
- ☐ Emphysema
- ☐ High Blood Pressure
- ☐ Low Blood Pressure
- ☐ Heart Attack
- ☐ Phlebitis
- ☐ Stroke/CVA
- ☐ Diabetes Mellitus
- ☐ Epilepsy
- ☐ Loss of Sensation
- ☐ Cancer
- ☐ Arthritis
- ☐ Headache
- ☐ Vision Loss
- ☐ Hearing Loss
- ☐ Ear Issues
- ☐ Pregnant
- ☐ Gynaecological Condition
- ☐ Caesarean Section
- ☐ Breast pain/Tenderness
- ☐ Tuberculosis
- ☐ HIV
- ☐ Hepatitis
- ☐ Skin Condition
- ☐ Constipation
- ☐ Allergies If yes, what:

____

____

Joint/Soft Tissue Discomfort:

- ☐ Neck
- ☐ Upper Back
- ☐ Mid Back
- ☐ Low Back
- ☐ Shoulders
- ☐ Arms
- ☐ Legs
- ☐ Knees
- ☐ Feet
- ☐ Hips
- ☐ Other: ______________________ ______________________

Is there any family history of the above? If yes, what? ____

Current Medications: ____

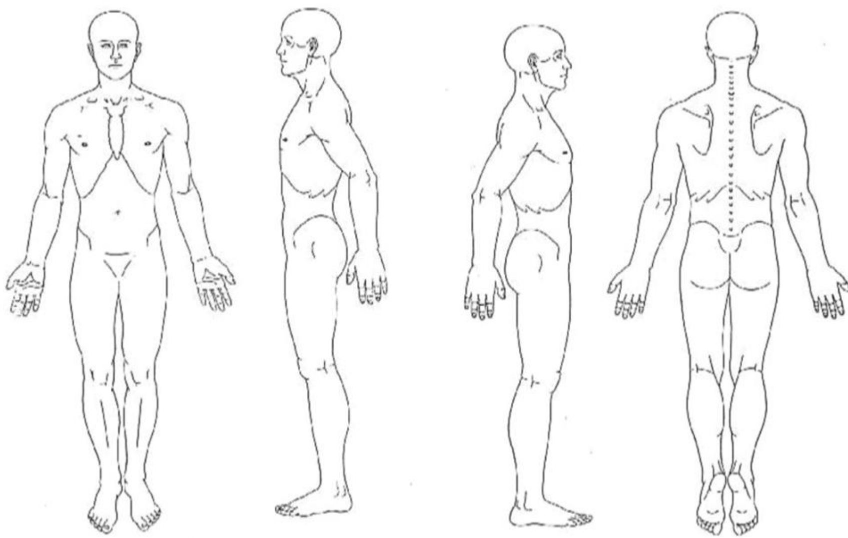
History of Surgery: ____

History of accidents or injuries: ____

Of special note (internal pins, wire, artificial joints, special equipment) ____________________________

Any allergies to Vitamin E, nuts, citrus, coconut? _______________________________________

THERAPIST'S NOTES



MASSAGE THERAPY INFORMED CONSENT

I understand that the massage therapist is providing massage therapy services within their scope of practice as defined by the Registered Massage Therapists' Association of Ontario.

I hereby consent for my therapist to treat me with massage therapy for the above noted purposes including assessments, examinations, and techniques, which may be recommended by my therapist.

I acknowledge that the therapist is not a physician and does not diagnose illness, disease, or any other physical or mental disorder. I clearly understand that massage therapy is not a substitute for a medical examination. I acknowledge no assurance or guarantee has been provider to me as to the results of the treatment. I acknowledge that with any treatment there can be risks, and that those risks have been explained to me, and I assume those risks.

I acknowledge and understand that the therapist must be fully aware of my existing medical conditions. I have completed my medical history form as provided my therapist, and have disclosed to the therapist all of those medical conditions affecting me. It is my responsibility to keep the massage therapist updated on my medical history. The information I have provided is true and complete to the best of my knowledge.

I authorize my therapists to release or obtain information pertaining to my condition(s) and/or treatment to/from my other caregivers or third party payers.

I have read the above noted consent, and I have had the opportunity to question the contents and my therapy. By signing this form, I confirm my consent to treatment and intend this consent to cover the treatment discussed with me, and such additional treatment proposed by my therapist from time to time, to deal with my physical condition and for which I sought treatment. **I understand that at any time I may withdraw my consent and treatment will be stopped.**

Patient Name: ____________________________ Signature of Patient/Guardian: ___________________________

Witness Signature: _________________________ Date Signed: ____