FIRST CARE CENTRE

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	☐ Shoulders	☐ Feet	☐ Other:
☐ Upper Back	☐ Arms	☐ Hips	_____
☐ Mid Back	☐ Legs		_____
☐ Low Back	☐ Knees		

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