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