Massage Therapy New Patient Intake Form

Name: ___________________________ Birthdate: ______________________
Address: ____
Phone: ___________________________ Email: __________________________

Would you like to receive our Monthly Newsletter? Yes No

Family Doctor: ___________________ Phone: __________________________
Care Card #: _____________________ ICBC or WCB Claim #: ___________

How did you hear about our clinic? ______________________________________

Please indicate if any of the following conditions apply to you with a check mark:

Heart Attack	Headaches/migraines	Join dislocation
High/low blood pressure	Dizziness/fainting	Bone fracture
Stroke/Aneurysm	Nausea	Arthritis
Pace maker/heart condition	Spinal injury	Osteoporosis
Varicose veins	Epilepsy/other seizures	Rods/pins/plates/shunts
Bruise easily	Other neurological condition	Transplant surgery
Diabetes	Asthma	Cancer
Kidney disease	Chronic sinusitis	Hepatitis
Other urinary condition	Irritable bowel/colitis	HIV/AIDS
Skin condition	Digestive issues	Other:

Please list any medications/supplements you currently take:

____

Known allergies:

____

Do you have any family medical conditions? Yes No
If yes, please list: ____

Ever been hospitalized, had any major accident, illnesses, or surgeries? Yes No

____

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Other therapy/treatment:

Service	**Date of last visit**	**Location**
Massage Therapy		
Chiropractor		
Physiotherapy		
Naturopath		
Acupuncture		
Other:		

List any activities, sports, hobbies:
____

Please circle how you CURRENTLY feel: (1 = poor, 5 = excellent)

Quality of sleep:	1	2	3	4	5
Energy level:	1	2	3	4	5
Eating habits:	1	2	3	4	5
Exercise habits:	1	2	3	4	5

Smoker: Yes No Occasional
Drinker: Yes No Occasional
Hours of sleep per night:
Number of meals per day:
Number of times you exercise per week:

<u>Current Condition:</u>

Please describe your current condition & symptoms: ________________________________

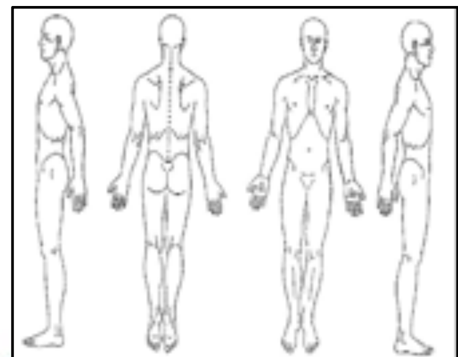
How long have you had this: ____________________

How did it start: ______________________________

What relieves it?______________________________

What aggravates it? ___________________________

Please indicate where it hurts



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<u>PLEASE NOTE:</u> Your appointment time has been reserved for you. We ask that you provide us with 24 hours notice of cancelation or a fee will be charged to your account. Payment for treatment is due in full, the day of service. All information you have provided is confidential and your therapist may contact your referring MD as deemed necessary for treatment success. By signing this intake form, you hereby consent to receiving treatment.

Signature: ________________________ **Date: _______________________________**