AFFINITY HEALTH CLINIC

Massage Therapy Health Intake Form

The information request below will assist us in treating you safely. Feel free to ask any questions about the information being requested. Please note that all information provided below will be kept confidential unless allowed or required by law. Your written permission will be required to release any information to anyone outside of this clinic.

Name:_____ Date: _____

Address: _____

City: _____ Province:_____ Postal Code: _____

Telephone - Home: _____ Cell:_____ Work:_____

Date of Birth: _____ Age: _____ Sex: _____

Occupation: _____

Emergency Contact: _____ Phone Number: _____

Have you received massage therapy before? □ Yes □ No

Did a health care practitioner refer you for massage therapy? □ Yes □ No

If yes, please provide their name and contact info if possible:

May we contact you via email regarding your appointments or ongoing treatments? □ Yes □ No

May we contact you via email regarding clinic updates and promotions? _____ YES _____ NO

Email address: _____

General Health Rating: 1 2 3 4 5

Poor Excellent

Is Your Visit Related To:

A recent Motor Vehicle Accident? □ Yes □ No If yes, date: _____

A Work Related injury/accident? □ Yes □ No If yes, date: _____

What is the reason you are seeking massage therapy? Please indicate the location of any tissue or joint discomfort:

_____ _____

_____

Medical Doctor:

Name: _____ Phone Number: _____

Address: _____

Please List all Surgeries / Injuries

Nature: _____ Date: _____

Nature: _____ Date: _____

Nature: _____ Date: _____

Please note presence of: internal pins / wires / rods / artificial joints

Location: _____

Current Medications / Supplements

Name: _____ Condition Treated: _____

Name: _____ Condition Treated: _____

Other Information

Is there any additional information your Massage Therapist should know?

_____

_____

PLEASE INDICATE CONDITIONS YOU ARE CURRENTLY EXPERIENCING OR HAVE EXPERIENCED:

RESPIRATORY

- ☐ Chronic Cough
- ☐ Shortness of Breath
- ☐ Bronchitis
- ☐ Asthma
- ☐ Emphysema

Do you smoke? YES NO

How Much? _____

Quit Date: _____

CARDIOVASCULAR

- ☐ High / Low Blood Pressure
- ☐ Congestive Heart Failure
- ☐ Heart Disease
- ☐ Heart Attack (date: _____)
- ☐ Stroke (date: _____)
- ☐ Phlebitis / DVT
- ☐ Varicose Veins
- ☐ Pacemaker
- ☐ Arterio/Atherosclerosis
- ☐ Dizziness / Vertigo

OTHER CONDITIONS

- ☐ Kidney/Bladder
- ☐ Gall bladder
- ☐ Liver
- ☐ Multiple Sclerosis
- ☐ Loss of Sensation
- ☐ Diabetes type:_____
- ☐ Epilepsy
- ☐ Cancer
- ☐ Osteoporosis
- ☐ Allergies
- ☐ Arthritis

Type:_____

HEAD/NECK

- ☐ Vision Problems
- ☐ Ear Pain / Ringing
- ☐ Hearing Loss L R
- ☐ Headaches
- ☐ Migraine / Tension / Sinus

SKIN

- ☐ Eczema
- ☐ Psoriasis
- ☐ Bruise Easily
- ☐ Rashes
- ☐ Plantar Warts

INFECTIONS

- ☐ Hepatitis A B C D
- ☐ Tuberculosis (treated: Y N)
- ☐ HIV
- ☐ AIDS
- ☐ Herpes
- ☐ Mononucleosis

INJURIES

- ☐ Sprains / Strains
  - Date: _____
  - Location: _____
- ☐ Whiplash
- ☐ Dislocation
  - Date: _____
  - Location: _____
- ☐ Fractures
  - Date: _____
  - Location: _____

SOFT TISSUE / JOINT DISCOMFORT

- ☐ Jaw R / L
- ☐ Neck R / L
- ☐ Upper Back R / L
- ☐ Mid Back R / L
- ☐ Low Back R / L
- ☐ Sacroiliac Joint R / L
- ☐ Hip R / L
- ☐ Legs R / L
- ☐ Knees R / L
- ☐ Ankles R / L
- ☐ Feet R / L
- ☐ Shoulder R / L
- ☐ Arm R / L
- ☐ Elbow R / L
- ☐ Wrist R / L
- ☐ Hands / Fingers R / L

WOMEN

- ☐ Pregnant (DOC:_____)
- ☐ Caesarean Section
- ☐ Menopausal Problems
- ☐ Menstruation Problems
- ☐ Heavy / Light / Absent / Painful

OTHER HEALTH CARE

- ☐ Chiropractic
- ☐ Acupuncture
- ☐ Naturopath
- ☐ Rehab (Physio) Therapy
- ☐ Other: _____

FAMILY HISTORY

- ☐ Arthritis

Type:_____

- ☐ Diabetes
- ☐ Cancer
- ☐ Other:_____

An accurate health history is important to ensure that it is safe for you to receive Massage Therapy and helps the therapist determine a proper treatment plan. All information given before, during and after treatments is held in strict confidence. You are required to inform us of changes in your condition prior to treatment.

Signature: _____ Date: _____

Health History Updated: _____ _____ _____