3 Waterloo St.
New Hamburg, ON
N3A 1S3

Intake Form – Massage Therapy

Name:_____Date: _____

Address: _____

City: _____Province:_____ Postal Code: _____

Telephone - Home:_____Cell:_____ Work:_____

Date of Birth: _____ Age: _____ Sex: _____

Occupation: _____

Emergency Contact:_____ Phone Number: _____

Referred By:_____

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:_____

General Health Rating: 1 2 3 4 5

Poor Excellent

Is Your Visit Related To:

1. A recent Motor Vehicle Accident? No ☐ ☐ Yes (date) _____
2. A Work Related injury/accident? ☐o ☐ _____Yes (date)

Reason for initial visit: _____

Have you had Massage Therapy? No ☐ Yes ☐

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: _____

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/Reflexology/Craniosacral 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. **I understand that 24 hours notice is required to cancel or full charges will apply. I also understand that if I miss an appointment charges will apply.** I consent to therapeutic massage/craniosacral therapy.

Signature: _____ Date: _____

Health History Updated: _____ _____ _____