



Massage Therapy Intake Form

Name:		Date:			
Address:					
City:		Province:		Postal Code:	
Date of Birth:					
Home #:		Work #:		Cell #:	
E-mail Address:					
Occupation:					
Who may we thank for referring you to this office? Name:					
Have you ever had a registered massage before?					
Do you exercise?			Frequency:		
Other daily activities:					
Did a health care practitioner refer you for massage: YES NO			If Yes, please provide their name and address: _____		
Chiropractor:			Doctor:		
What is your primary reason for your visit today:					
Do you have any other medical conditions:					
Describe any surgeries you have had:					
Do you have any pins, wires, artificial joints or special equipment:					
Describe any accidents you have had:					
List any medications that you take:					
Headaches/Migraines	Yes	No	Stiff/painful joints	Yes	No
Vision loss/problems			Loss of sensation: Where?		
Hearing loss			Sinus		
Chronic cough			Sciatica		
Bronchitis/Emphysema/ Asthma			Depression		
Allergies to scents			Blood clots		
Allergies in general			Stroke		
Arthritis			Heart disease/Heart Attack		
Osteoporosis			High/Low blood pressure		
Scoliosis			Poor circulation		
Broken bones			Asthma		
Disc problems			Thyroid dysfunction		
Spasms/cramps			Diabetes		
TMJ (jaw pain)			Currently pregnant/Due Date		
Tendonitis			Malignant cancer/tumor		
Spinal problems			Benign cancer/tumor		
Phlebitis/Varicose veins			Any infections		



Would you like to receive our newsletter by email? Please Circle below:

Yes No

Contract for Care:

I promise to participate fully as a member of my health care team. I will make sound choices regarding my treatment plan and the information provided by my Massage Therapist and other members of my health care team. I agree to participate in the self-care program that we select. I promise to inform my health care team any time I feel my well-being is threatened or compromised. I expect my massage therapist to provide a safe and effective treatment.

Consent for Care:

It is my choice to receive massage therapy, and I give my consent to receive treatment. I understand that massage therapists DO NOT diagnose illness, disease, or any other physical or mental disorder. Massage therapy is not a substitution for medical examination and/or diagnosis. I affirm that I have stated all my known medical conditions and shall take upon myself to keep my massage therapist updated on my physical/mental health. I also agree there shall be no liability on the practitioner's part should I neglect to do so.

Signature:

_____ Date: _____

Signature of parent/guardian:

_____ Date: _____