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		

25 Stonebridge Unit 2, Wasaga Beach, ON L9Z 0C1
T: 705-422-0224 F: 705-422-7109

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: _____

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