November 2018

MASSAGE THERAPY INTAKE FORM

BEACON HILL
CHIROPRACTIC AND MASSAGE

As a full spectrum Chiropractic clinic; we focus on your ability to be healthy. Our goals are, first, to address the issues that brought you to this office, and second, to offer you the opportunity of improved health potential and wellness services in the future. On a daily basis we experience physical, chemical and emotional stress that can accumulate and result in serious loss of health potential. Most times the effects are gradual, not even felt until they become serious. Please complete this document so we are better able to address your specific health concerns and challenges. Massage Therapy is great for a variety of reasons. Pain relief, injury recovery, mobility improvement, and correction of whatever is malfunctioning in the body, are all areas of healthcare our therapists are capable of treating.

Please check the type of care desired so that we can best serve your health care needs:

- ◯ **Relief Care** – Symptom relief of pain or discomfort
- ◯ **Corrective Care** – Relieving both cause and symptoms of pain or discomfort
- ◯ **Comprehensive Care** – Use of muscle therapy to bring my body to the best state possible
- ◯ I want the Massage Therapist to select my treatment plan

Full Name: _____ ***M / F*** ***AHC #:*** _____

Date of Birth (M/D/Y): _____ **Age:** _____ **Occupation:** _____

Address: _____ **City:** _____ **Prov:** _____ **Postal Code:** _____

Home phone: _____ **Cell phone:** _____ **Work Phone:** _____

Name of Spouse: _____ **Children? Y / N How Many?:** _____

Alternate Emergency Contact: _____ **Phone Number:** _____

If under 18, Name of Parents: _____

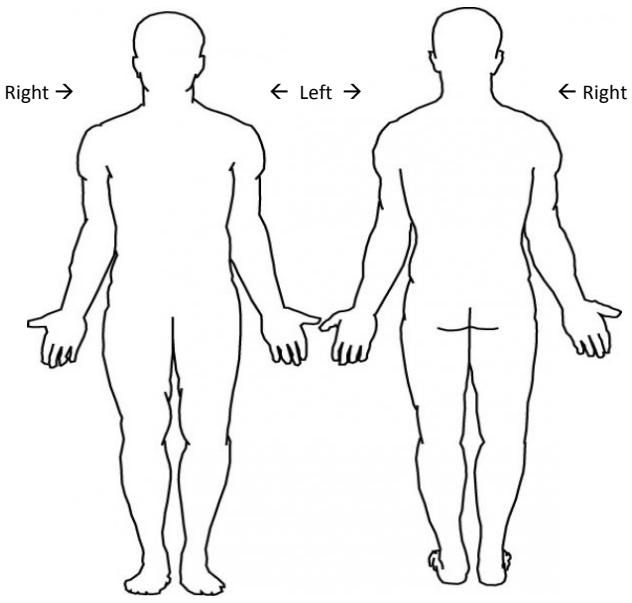
Do you consent to emails regarding appointment reminders and clinic/health information? ___ Yes ___ No

Email: _____ **Initials:** _____

Pain/Discomfort Diagram:

Please mark these diagrams according to where you feel pain. Please also indicate which sensations you feel by referring to the key below:

KEY
///// Stabbing
XXXX Aching
Burning
>>>> Pins/Needles
0000 Numbness



PLEASE CIRCLE YOUR CURRENT PAIN LEVEL

0 1 2 3 4 5 6 7 8 9 10

0-3 – No pain; Mild pain **4-7** – Moderate pain; medication required **8-10** – Severe pain; daily life impacted

FULL NAME: _____

Please **CHECK** any current/past conditions

CARDIOVASCULAR
- ◯ Angina
- ◯ Blood clots
- ◯ Blood pressure: HIGH
- ◯ Blood pressure: LOW
- ◯ Congenital heart defect
- ◯ Hardening of arteries
- ◯ Heart attack
- ◯ Heart murmur
- ◯ Heart surgery
- ◯ Hemophilia
- ◯ Hypertension
- ◯ Pace maker
- ◯ Poor circulation
- ◯ Stroke
- ◯ Thrombosis
- ◯ Varicose veins

RESPIRATORY
- ◯ Asthma
- ◯ Chest pain
- ◯ Emphysema (short of breath)
- ◯ Pneumonia
- ◯ Pulmonary hypertension

GASTROINTESTINAL
- ◯ Constipation
- ◯ Crohn's or Colitis
- ◯ Digestive problems
- ◯ Gallbladder/Jaundice
- ◯ IBS or IBD
- ◯ Nausea
- ◯ Vomiting

MUSCLE/BONE/JOINT
- ◯ Arthritis
- ◯ Back pain
- ◯ Bursitis
- ◯ Cortisone injections
- ◯ Degenerative disease
- ◯ Fractures/Breaks: _____
- ◯ Inflammation
- ◯ Osteopenia
- ◯ Osteoporosis
- ◯ Plates/Pins: _____ _____
- ◯ Rheumatoid arthritis
- ◯ Sciatica
- ◯ Scoliosis
- ◯ Spinal disc problems
- ◯ Sprain/Strain
- ◯ Trauma/Falls
- ◯ Weakness/Instability
- ◯ Whiplash

HEAD & NECK
- ◯ Dizziness
- ◯ Ear infection
- ◯ Eyesight problems
- ◯ Hearing loss
- ◯ Neck pain
- ◯ Ringing in ears (tinnitus)
- ◯ Sinus problems
- ◯ TMJ disorder
- ◯ Vertigo
- ◯ Whiplash

NEUROLOGICAL
- ◯ Alzheimer's/dimentia
- ◯ Brain injury
- ◯ Cerebral palsy
- ◯ Epilepsy
- ◯ Fainting
- ◯ Headaches/Migraines
- ◯ Loss of motor control
- ◯ Meningitis
- ◯ Multiple Sclerosis (MS)
- ◯ Narcolepsy/Insomnia
- ◯ Nerve damage: _____
- ◯ Numbness in arms/legs/ hands/feet/_____
- ◯ Parkinson's/ Seizures

SKIN CONDITIONS
- ◯ Acne
- ◯ Athlete's foot
- ◯ Eczema
- ◯ Keloid/Scarring
- ◯ Psoriasis
- ◯ Shingles
- ◯ Warts

WOMEN ONLY
- ◯ Cramps or back pain
- ◯ Menopause
- ◯ Miscarriage
- ◯ New mother
- ◯ Nursing
- ◯ Pregnant

DIAGNOSED CONDITIONS
- ◯ ADD/ADHD
- ◯ Autoimmune disease
  Cancer: _____ _____
- ◯ Diabetes (I / II)
- ◯ Hepatitis
- ◯ HIV/AIDS
- ◯ Infectious disease: _____
- ◯ Kidney disease
- ◯ Raynaud's
- ◯ Rheumatic fever
- ◯ Tuberculosis

MENTAL HEALTH
- ◯ Anxiety
- ◯ Bipolar disorder
- ◯ Eating disorder
- ◯ Depression
- ◯ Panic attacks
- ◯ Postpartum depression
- ◯ PTSD
- ◯ Stress

ALLERGIES

Allergic to: _____
_____
_____
Reaction: _____
_____
- ◯ EpiPen? YES / NO

Please list any **medications** you may be taking:

_____

Please list any **surgeries/falls/accidents** and their dates:

_____

Do you **consume/use** any of the following?

Smoking: ☐ Y ☐ N **Alcohol:** ☐ Y ☐ N **Coffee:** ☐ Y ☐ N **Cannabis (smoke/edibles):** ☐ Y ☐ N **CBD Oil:** ☐ Y ☐ N

Please note that treatment will be withheld for any patient under the influence of alcohol or non-prescription drugs

What have you tried for relief?

☐ Heat/Cold ☐ Exercise/stretching ☐ Chiropractic ☐ Physiotherapy ☐ Massage ☐ Acupuncture ☐ Other: _____

Do you enjoy conversation during treatment? ☐ Sometimes ☐ Yes ☐ No

Are there areas of your body that you prefer not to be massaged? - Please specify: _____

What is your preferred style of massage? ☐ Relaxation/Stress relief ☐ Deep tissue ☐ Full body ☐ Other: _____

****Please communicate your pressure/comfort preference with your therapist DURING each massage!!**

Please Read and Sign:

THIS AGREEMENT AND THE CONTENTS OF THIS FILE ARE CONFIDENTIAL.
DATA WILL NOT BE SHARED OUTSIDE OF BEACON HILL CHIROPRACTIC AND MASSAGE WITHOUT CLIENT PERMISSION.
THE INFORMATION DISCLOSED IS TO ASSIST THE THERAPISTS IN PROVIDING THE SAFEST AND MOST EFFECTIVE TREATMENT PLAN FOR YOU.

Massage therapy has been demonstrated to be beneficial in the relief of pain produced via nerve, muscle, and joint ailments. Treatment of the neck, back, and limbs can alleviate pain of headaches, phantom sensations, muscle aches/spasms, and stiffness. Massage can also increase mobility, improve muscle function, and reduce the need for drugs or surgery. Any potential risks associated with massage therapy include the temporary worsening of symptoms, skin irritation, as well as sprain and/or strain of ligaments, muscles, and joints. These risks vary per patient dependant on condition, location, and type of treatment.

I understand that the massage therapist is providing services within their scope of practice. I hereby consent for my therapist to treat me for the above noted purposes including any such assessments, examinations, and techniques which may be recommended. I acknowledge the massage therapist is not a physician and therefore does not diagnose illness, disease, or disorders of the physical and mental scope. I understand that massage is not a substitute for a medical appointment and it is recommended that I visit my personal physician for any ailments I experience. I acknowledge that no assurance or guarantee has been provided to me regarding my treatment and I understand and assume the risks associated with massage therapy.

I understand that treatment provided by the massage therapist when requested without a previous chiropractic exam/assessment is separate and distinct from the practice of any current or future chiropractic doctors of Beacon Hill Chiropractic & Massage. I hereby waive all liability towards the doctors directly or indirectly, should any injury or malpractice occur from treatment provided by the massage therapist.

I understand that I must disclose all existing medical conditions to the massage therapist, and I have completed my medical history form to the best of my knowledge, ability and truth. It is my responsibility to update my therapist on any changes to my medical status and history.

_____
Initial

I am aware that massage appointments are comprehensive. *Change time and consultation time are included within your designated appointment time, as well as any assessments, exercise recommendations, and review of health history.*

I understand that payment is expected at the time of service AND that if I fail to cancel an appointment 24 hours in advance, or have missed an appointment, I will be charged the following cancellation fees:

First Time – Warning
Second Time – 100% of massage price

_____
Initial

I have read the above noted consent, I have had the opportunity to consider the benefits and risks associated with massage therapy and I am choosing to continue with treatment. By signing this form, I confirm consent to treatment and intend consent to cover any and all related in-clinic treatments and at-home care proposed by my therapist. I understand at any time I am able to withdraw my consent and treatment will be stopped.

_____	_____	_____
Patient Full Name (Print Legibly)	*Signature*	*Date (M/D/Y)*

If under the age of 18:

_____	_____	_____
Parent Name (Print Legibly)	*Signature*	*Date (M/D/Y)*

Thank you for choosing the Beacon Hill Chiropractic and Massage team to assist you with your healthcare goals! ☺