Massage Intake Form

File #

Today's Date: M M / D D / Y E A R

Whom may we thank for referring you to our office? NAME _____

○ Google ○ Walk-in ○ Word of mouth ○ Other _____

Is this a motor vehicle accident claim? ○ Yes ○ No **Is this a workers compensation board claim?** ○ Yes ○ No

Personal Information

Name FIRST _____ LAST _____ **Sex** ○ Male ○ Female

Address _____ CITY _____ PROV _____ POSTAL CODE _____

Email Address _____

Phone # HOME _____ CELL _____ WORK _____

Marital Status ○ Single ○ Married ○ Widowed ○ Divorced ○ Separated ○ Common Law

Birth Date YYYY/MM/DD _____/_____/_____ **Age** _____ **Alberta Health Care #** _____

Spouse/Partner Name FIRST _____ LAST _____ ○ Not Applicable

# of Children IF APPLICABLE _____ **Names and Ages** _____

Occupation _____ **Employer** _____

Hobbies/Recreation/Likes _____

Emergency Contact

Name FIRST _____ LAST _____ **Relationship** ○ Spouse ○ Relative ○ Friend

Phone # HOME _____ CELL _____ WORK _____

Current Health Professionals

Medical Doctor NAME _____ PHONE _____

ADDRESS _____ CITY _____ PROV _____ POSTAL CODE _____

Dentist NAME _____ PHONE _____

ADDRESS _____ CITY _____ PROV _____ POSTAL CODE _____

Other NAME _____ PHONE _____

ADDRESS _____ CITY _____ PROV _____ POSTAL CODE _____

Chief Complaint

Describe: _____

When did it start? _____

Has it occurred before? ● no ● yes **When?** _____

Severity: 0 (BEST) **- 10** (WORST) _____

How often does it occur? _____

How long does it last? _____

Location(s): _____

Quality: ● dull/aching ● sharp ● stabbing ● throbbing

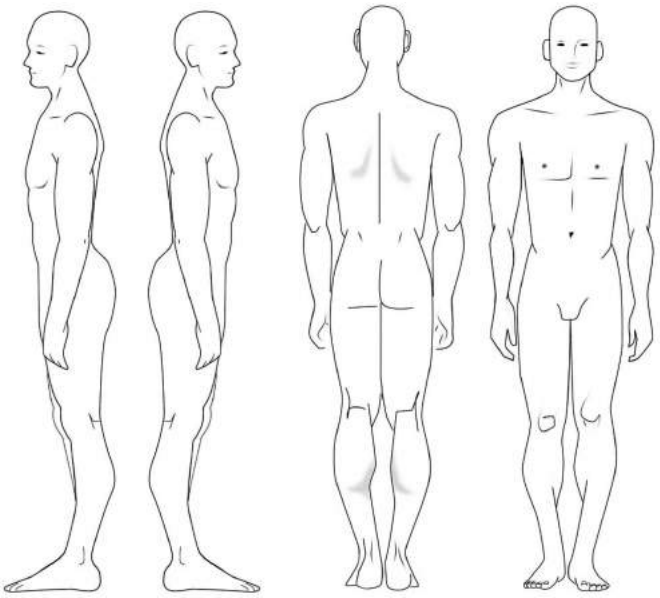
Timing: ● all day ● morning ● evening ● with activity

It is: ● getting worse ● getting better ● staying the same

What makes it better? _____

What makes it worse? _____

PLEASE SHADE THE AREAS OF DISCOMFORT



What care have you received? _____ **Was it helpful?** ● yes ● no

Prior Health History

Have you had massage therapy before? ● yes ● no **Was it helpful?** ● yes ● no

Are you receiving chiropractic care? ● yes ● no **Was it helpful?** ● yes ● no

Injuries PLEASE LIST INJURIES SUCH AS A **FRACTURES**, **FALLS**, **BROKEN BONES**, **HEAD INJURIES**, **LACERATIONS** ETC,

DATE _____ INJURY _____ DATE _____ INJURY _____

DATE _____ INJURY _____ DATE _____ INJURY _____

Motor Vehicle Accidents PLEASE LIST DATES, TYPE (**REAR END**, **FRONT**, **T-BONE,** OR **OTHER),** AND IMPACT (**HIGH**, **MEDIUM**, OR **LOW**).

DATE _____ ● REAR END ● FRONT ● T-BONE ● OTHER _____ ● HIGH IMPACT ● MEDIUM IMPACT ● LOW IMPACT

DATE _____ ● REAR END ● FRONT ● T-BONE ● OTHER _____ ● HIGH IMPACT ● MEDIUM IMPACT ● LOW IMPACT

Are you currently experiencing any of the following? ● Flu/Cold/Fever? ● Infection? ● Contagious Disease?

Do you have sensitive skin? ● yes ● no **Do you have allergies to oils, lotions, ointments, fruits or nuts?** ● no ● yes **Explain**:

_____

Is there anything else about your health history that you think would be beneficial for your massage therapist to know to plan a safe and effective massage session for you? ● no ● yes **Explain**: _____

_____

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Current Lifestyle Choices

Exercise ● Never ● 1x/wk ● 2-3x/wk ● 4-5x/wk ● Every Day ● Occasional ● 'Weekend Warrior'

Tobacco ● Never ● Live(d) With Smoker ● Quit Smoking ● Cigarettes/Cigars/Chew _____ PER DAY

Alcohol ● Never ● Occasional ● _____ DRINKS PER WEEK **Coffee/Caffeine** ● Never ● Occasional ● _____ CUPS PER DAY

Water _____ GLASSES PER DAY **Fruits/Veggies** _____ PER DAY **Sugar Snacks** ● Never ● Occasional ● Daily

Hours of Sleep HOURS/NIGHT _____ **Do you feel rested when you wake up?** ● Yes ● No **Do you get daily quiet time?** ● No ● Yes

Rate your stress level MARK 0 = **NONE** / 10 = **EXTREME** Occupational _____ Personal _____

Rate your lifestyle MARK **POOR**, **GOOD**, OR **EXCELLENT** Diet _____ Sleep _____ General Health _____

PLEASE CHECK ALL THAT APPLY. **CIRCLE AREAS THAT ARE OF SERIOUS CONCERN OR MORE PROMINENT.**

AIDS ●	Excess stress ●	Arthritis ●
High blood pressure ●	Numbness/tingling ●	Sprains/strains ●
Low blood pressure ●	Insomnia ●	Back pain ●
Bursitis ●	Headaches/migraines ●	Neck pain ●
Swollen feet/legs ●	Diabetes ●	Joint pain ●
Heart trouble ●	Seizures ●	Muscle tention ●
Varicose veins ●	Phlebitis ●	Disc problems ●
Poor circulation ●	Stroke ●	●
Hemophilia ●	Skin problems ●	**For women only:** ●
Allergies ●	Digestive problems ●	Menstural cramps ●
Cancer ●	Constipation ●	Lack of periods ●
Anemia ●	Anxiety ●	Menapausal ●
Sciatica ●	Muscle spasms ●	Pregnant ●

Acknowledgement

I understand that massage is give at **PRECISION**SPINALCARE for the purpose of stress reduction, relief from muscular tension, spasms or pain, and for increasing circulation and/or energy flow. I understand that the massage therapist does not diagnose illness, disease, or any other physical or mental disorder. As such, the massage therapist does not prescribe medical or pharmaceutical treatment, nor do they perform spinal manipulations. It has been made clear to me that it is recommended that I see a physician for any physical ailment I might have. I have stated all my known medical conditions and take it upon myself to keep the massage therapist updated on my physical health.

I understand that payment is expected at the time of the visit unless previous arrangements have been made. I agree that if I fail to cancel an appointment 24 hours in advance, that I will be charged for the missed appointment.

Name _____ **Signature** _____ **Date** _____