Massage Therapy Intake Form

- Lewis Estates Chiropractic & Massage Clinic

PLEASE PRINT CLEARLY.

First name: _____ Last name: _____Male___ Female___

Address: _____City: _____

Province: _____ Postal Code: _____

Home#:_____-_____- _____Bus#: _____-_____- _____ Cell#: ____-_____- _____

Date of Birth: _____(m) _____ (d) _____(y) Occupation: _____

Medical Doctor: _____

How did you hear about us: _____

Email: _____

Receipt preference: Printing ___ Email ____

Client Agreement

I agree to give **24 hour notice** on appointment that I cannot make and must cancel.

I am also aware that **50% penalty fee** for the total cost of the massage may be charged on my account for appointment that I miss and do not give sufficient notice to cancel or reschedule.

Signature: _____Date: _____(m)_____(d)_____(Y)

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PLEASE PRINT CLEARLY. Date: _____ (m) _____(d)_____(Y)

First name: _____ Last name: _____

Date of Birth: _____(m) _____ (d) _____(y) Male:____ Female: ____

Please indicate conditions you are experiencing or have experienced:

Cardiovascular
- ❒ High blood pressure
- ❒ Low blood pressure
- ❒ Chronic congestive heart failure
- ❒ Heart attack
- ❒ Phlebitis / varicose veins
- ❒ Stroke / CVA
- ❒ Pacemaker or similar device
- ❒ Heart disease
- ❒ Dizziness / vertigo
- ❒ Seizures

Is there a family history of any of the above? ❒ Yes ❒ No

Respiratory
- ❒ Asthma
- ❒ Bronchitis
- ❒ Emphysema
- ❒ Chronic Cough
- ❒ Shortness of breath

Is there a family history of any of the above? ❒ Yes ❒ No

Digestive
- ❒ Constipation
- ❒ Chrones Disease
- ❒ Colitis
- ❒ Irritable Bowel Syndrome
- ❒ Ulcers

Head and Neck
- ❒ History of headaches
- ❒ History of migraines
- ❒ Vision problems
- ❒ Vision loss
- ❒ Ear problems
- ❒ Hearing loss

Muscle/Joint
- ❒ Neck
- ❒ Back (lower)
- ❒ Back (mid)
- ❒ Back (upper)
- ❒ Shoulders
- ❒ Elbow
- ❒ Wrist / Hand
- ❒ Hip
- ❒ Knee
- ❒ Ankle / Foot
- ❒ Spine

Other
- ❒ Loss of sensation
  Where? _____
- ❒ Diabetes
  Onset: _____
  Type: _____
- ❒ Allergies / hypersensitivity
  What? _____
- ❒ Epilepsy
- ❒ Cancer
  Type/Location: _____
- ❒ Arthritis
  Is there a family history of arthritis? ❒ Yes ❒ No
- ❒ Hemophilia
- ❒ Fibromyalgia
- ❒ Chronic fatigue
- ❒ Scoliosis
- ❒ Polio / Post Polio
- ❒ Osteoporosis

Women
- ❒ Pregnancy
  Due Date: _____
- ❒ Previous pregnancy complications
  _____
  _____
- ❒ Menopausal problems
  _____
- ❒ Menstrual problems
  _____
- ❒ Gynecological conditions
  Describe: _____

Infectious Conditions
- ❒ Skin Conditions
  Describe: _____
- ❒ Respiratory Conditions
  Describe: _____
- ❒ Hepatitis

Skin Conditions
- ❒ Eczema
- ❒ Psoriasis
- ❒ Rash
- ❒ Warts
- ❒ Open Sores

Men
- ❒ Enlarged Prostate
- ❒ Libido Issues
- ❒ Other
  _____

Do you have any medical conditions not listed above? ❒ Yes ❒ No
If yes, please describe: _____

Do you have any internal wires, artificial joints, pacemakers or special equipment that we should be aware of? ❒ Yes ❒ No

_____

Please circle areas which are currently causing you symptoms of pain, stiffness, numbness or other forms of discomfort

Face	Upper back	Arm(s)	Hand(s)	Thigh(s)	Ankle(s)	Neck
Mid back	Elbow(s)	Finger(s)	Knee(s)	Feet	Shoulder(s)	Lower back
Wrist(s)	Hip(s)	Leg(s)	Toe(s)	Chest	Ribs	Tailbone

For what condition or reason are you seeking treatment today? _____

_____

Have you seen any other health care professional(s) for this condition or reason? ❒ Yes ❒ No
If yes whom? _____

Have you ever been involved in any motor vehicle accidents? ❒ Yes ❒ No Date: _____
Have you been involved in any other accidents? ❒ Yes ❒ No Date: _____
Have you ever been knocked unconscious? ❒ Yes ❒ No Date: _____

Briefly list any surgeries you have undergone, for what and when.

_____

_____

Are you presently taking any prescribed medication(s)? ❒ Yes ❒ No
If yes, please list the medication(s) and the condition(s) for which it is being used if known.

_____

_____

Have you previously received massage therapy treatments? ❒ Yes ❒ No
If yes, were you treated: ❒ At this clinic ❒ From an RMT ❒ Other

Please circle on the following scales the extent to which you are currently satisfied with the following:
(*5 represents total satisfaction, 1 represents little or no satisfaction*)

Physical health & fitness	5	4	3	2	1
Mental & emotional happiness	5	4	3	2	1
Energy level	5	4	3	2	1
Diet	5	4	3	2	1
Ability to relax	5	4	3	2	1

I acknowledge that the Massage Therapist is not a physician and does not diagnose illness or disease or any other physical or mental disorder. I clearly understand that massage therapy is not a substitute for a medical examination. It is recommended that I attend my personal physician for any ailment that I may be experiencing. I acknowledge that no assurance or guarantee has been provided to me as to the results of the treatment.

I acknowledge and understand that the Massage Therapist must be fully aware of my existing medical conditions. I have completed my medical history form as provided by my Massage Therapist and disclosed all of those medical conditions affecting me. It is my responsibility to keep the Massage Therapist updated on my medical history. The information I have provided is true and complete to the best of my knowledge.

Signature (Patient) Date Therapist Signature