GRANGE LEWIS ESTATES
CHIROPRACTIC & MASSAGE
& ACUPUNCTURE CLINIC

WINDERMERE
CHIROPRACTOR
& PHYSIOTHERAPY CLINIC

Massage Therapy Intake Form

First Name:____________________ Last Name:______________________ Male___Female___

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

Address:____ City:______________________

Province:______________ Postal code:_______________

Home phone:________________________ Cell:_____________________________

Email:____

Client Agreement

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

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

Signature:___________________________________ Date: (m)_____ (d)_____ (y)_______

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Massage Therapy Intake Form

First name:__________ Last name:__________ DOB:__________ 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

is there a family history of any of the above?
- ☐ Yes
- ☐ No

Respiratory
- ☐ chronic cough
- ☐ shortness of breath
- ☐ bronchitis
- ☐ asthma
- ☐ emphysema

is there a family history of any of the above?
- ☐ Yes
- ☐ No

Infections
- ☐ hepatitis
- ☐ skin conditions
- ☐ TB
- ☐ HIV
- ☐ herpes

Head / Neck
- ☐ history of headaches
- ☐ history of migraines
- ☐ vision problems
- ☐ vision loss
- ☐ ear problems
- ☐ hearing loss

Women
- ☐ pregnant, due:__________
- ☐ gynaecological conditions, what?__________

Other Conditions
- ☐ loss of sensation, where? __________
- ☐ diabetes, onset: _______
- ☐ allergies / hypersensitivity to what? __________
  type of reaction: __________
- ☐ epilepsy
- ☐ cancer, where? __________
- ☐ skin conditions, what? __________
- ☐ arthritis

is there a family history of arthritis?
- ☐ Yes
- ☐ No

Overall, how is your general health? __________

Current Medications and condition it treats: __________

Are you currently receiving treatment from another health care professional?
- ☐ Yes
- ☐ No

If yes, for what?__________

Surgery — date:__________
nature:__________

Injury — date:__________
nature:__________

Do you have any other medical conditions? (e.g. digestive conditions, haemophilia, osteoporosis, mental illness).
- ☐ Yes
- ☐ No

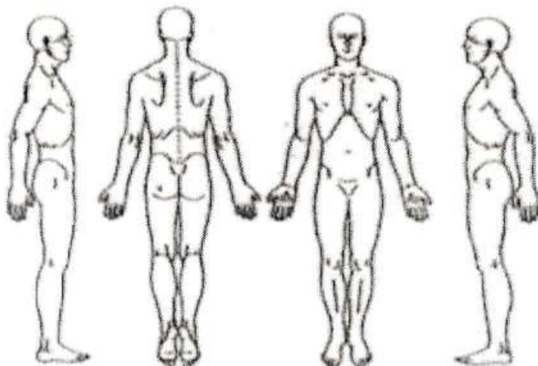
what?__________

Do you have any internal pins, wires, artificial joints, or special equipment?
- ☐ Yes
- ☐ No

what?__________
where?__________

What is the reason you are seeking massage therapy?
Please include the location of any tissue or joint discomfort.
____
____
____

Please circle any areas of discomfort



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.

Client Signature__________ Date__________
Therapist Signature__________ Date__________