Mommy&Me
Family Chiropractic

**Massage Therapy Client Intake Form** Today's date:_____

Patients Name :_____Referred by:_____
Home Address:_____
Postal code:_____ City:_____Province:_____
Phone:(H)_____(C)_____(W)_____
Occupation: _____E-mail Address: _____
Emergency Contact:_____(Ph.)_____

## Massage History

Have you previously seen a Massage therapist? ☐Y ☐N
If Yes, when was your last visit ?_____
Were you referred by a healthcare professional? ☐Y ☐N
When was your last visit with a physician? _____

## Current Health Condition

Reason for today's visit? _____
When did it start?_____ Why do you think it started?_____
How has your condition/pain been progressing: ☐ Getting worse ☐ Better ☐ Staying the same
Does anything make your condition/pain better? _____
Does anything make your condition/pain worse? _____
Is your condition/pain worse during certain times of the day? _____
Rate your pain/ discomfort on a scale of 0-10 with 0 being no pain/discomfort and 10 being the worst pain/ discomfort imaginable:
At it's best: _____At it's worst: _____ Currently:_____
Are you experiencing any other signs/symptoms that go along with your main concern? ☐Y ☐N If yes, please explain:
_____
Have you seen anyone else for this complaint? ☐Y ☐N If yes, with whom? _____
What were the results? _____
What was the treatment? _____
Are you currently taking any prescribed or OTC medications? ☐Y ☐N
If yes, please list:_____
Are you currently using any home remedies? ☐Y ☐N
If yes, please list: _____

**Please check all symptoms you are currently experiencing or have in the past:**

| | | | | |
|---|---|---|---|---|
| □ Neck Pain | □ Fatigue | □ Skin condition | □ Chronic Pain | □ Neurological Condition |
| □ Whiplash | □ Nausea | □ Thigh Pain | □ Respiratory Condition | **Pins & Needles in**: |
| □ Sleeping Problems | □ Digestive Conditions | □ Pubic Pain | □ Numbness | □ **Legs** □ **Arms** |
| □ Back Pain | □ High or low blood pressure | □ Fainting | □ Infectious Condition | □ **Fingers**□ **Toes** |
| □ Tension | □ Cardiovascular condition | □ Difficulty Swallowing | □ Depression | Other:_____ |
| □ Chest Pains | □ Loss of Balance | □ Diarrhea | □ Cancer | _____ |
| □ Shortness of Breath | □ Asthma | □ Cold hands or feet | □ Multiple Sclerosis | _____ |
| □ Headaches/ migraines | □ Allergies | □ Dizziness | □ Leg / Calf cramps | _____ |
| □ Diabetes | | □ Weakness | | _____ |
| | | □ Double Vision | | |

**Accidents/Traumas/Injuries**

No. of car accidents: _____ Approximate dates: _____

Any Injuries/ broken bones? ☐Y ☐N If yes, please explain _____

Any Hospitalizations? ☐Y ☐N If yes, please explain _____

Any Surgeries? ☐Y ☐N If yes, please explain: _____

Please list family medical history:_____

**Current Health**

How often would you say you engaged in physical activity: ☐0x/wk ☐1-3x/wk ☐4-7x/wk

How would you describe your diet: ☐ poor ☐fair ☐good ☐excellent

Do you smoke? ☐Y ☐N How many cigarettes per day? _____

Do you drink alcohol? ☐Y ☐N How many drinks per week? _____

What are your health goals? _____

_____

**Informed Consent**

1. I understand that I have the right to ask questions and be fully informed about any proposed treatment. I can refuse or stop any part of the assessment or treatment at any time.
2. I understand that massage therapy appointments will include an oral consultation, physical assessment, massage treatment, and/or hydrotherapy and remedial exercises.
3. I agree to keep the therapist fully informed about my current health status and personal information; And I will not hold the therapist or the facility for any unforeseen medical complications.
4. I understand this information is confidential and protected by the Personal Health Information Act (PHIA)

Signature:_____ Date:_____