Date Completed: ______________________

Massage Therapy Intake Form

Personal Information:

Name: ______________________ Birth Date: ______________________

Address: ______________________ City: ______________________

Province: ______________________ Postal Code: ______________________

Home Phone: ______________________ Cell Phone: ______________________

Occupation: ______________________ Work Phone: ______________________

Email Address: ______________________

Family Doctor: ______________________ Referred By: ______________________

Emergency Contact: ______________________ Phone: ______________________

Care Card Number: ______________________ Extended Medical Insurer: ______________________

Is this an ICBC Claim? Yes No If yes, please complete the following:

Date of Accident: ______________________ ICBC Claim Number: ______________________

Adjuster's Name: ______________________ Phone Number: ______________________

Current Condition:

Reason for Appointment: ______________________

____

When did this begin? ______________________

Have you experienced something similar before?

Yes No ______________________

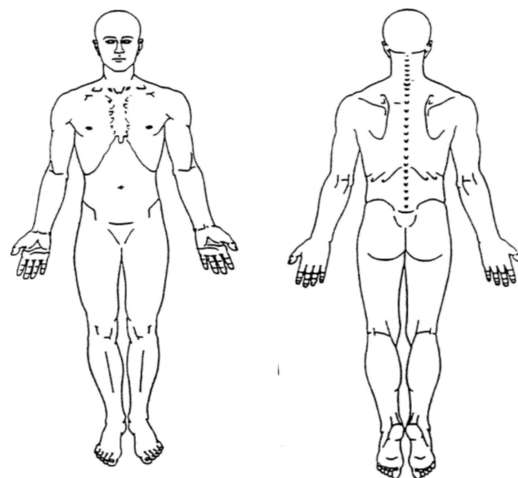
What aggravates it? ______________________

What relieves it? ______________________

Have you seen any other practitioners regarding this?

Yes No ______________________

Please Use the Diagram Below to Indicate Your Symptoms:



Aching O O
Stabbing X X X
Shooting → →
Numbness # # #

Have you had any diagnostic imaging done for this condition (X-rays, ultrasound, MRI, etc.)?

Yes No If yes, what and when? ______________________

Date Completed: ________________________

Health History:

Please list any previous surgeries, illnesses or injuries: ____

____

List all current medications and the conditions that they treat: ______________________________________

____

Any known allergies (including medications, seasonal, foods, lotions, etc.) ___________________________

____

Please indicate all that apply using the appropriate letter in the boxes below: C = Current P = Past

	High or Low Blood Pressure		Dizziness/Fainting		Eczema or Psoriasis
	Heart Attack		Nausea		Joint Dislocation
	Stroke or Aneurysm		Spinal Cord Injury		Bone Fracture(s)
	Pacemaker		Head Injury		Arthritis
	Other Heart Conditions		Epilepsy		Osteoporosis
	Varicose Veins or DVT		Other Neurological Conditions		Rods, Pins, Plates
	Other Circulatory Conditions		Asthma		Autoimmune Condition(s)
	Diabetes		Other Respiratory Conditions		Cancer
	Kidney Disease		Crohn's/Ulcerative Colitis		Tuberculosis
	Other Urinary Conditions		Irritable Bowel Syndrome		Hepatitis A/B/C
	Headaches/Migraines		Other Digestive Conditions		HIV/AIDS

Current sleep quality? Good Fair Poor Current dietary habits? Good Fair Poor

Are you physically active? Yes No How often? _______________/week

Type(s) of exercise? ____

Preferred Method for Appointment Reminders:

_____ Email ______ Text Message If text, who is your service provider? _____________________

Client Signature: _____________________________________ **Date:** ___________________________

Therapist Signature: __________________________________ **Date:** ___________________________