



THE MASSAGE CLINIC ~ *Counselling Intake Form*

575 River Glen Blvd, Unit 7 • Oakville, ON • L6H 6X6

 905-257-5888  info@themassageclinic.ca

Date of Referral (mm/dd/yy): _____

Client Name: _____

Gender: Male Female

Date of Birth (mm/dd/yy): _____

Address: _____

Home Phone: _____ Work: _____ Cell: _____

Please indicate where messages can be left

I consent to The Massage Clinic Reception contacting me regarding scheduling and appointment reminders:

Yes No

Where did you hear of this service?

- The Massage Clinic Psychology Today Website
 Findasocialworker.com Website NetworkTherapy.com Website
 Other (please specify):

Relevant Medical and/or Mental Health History:

Reason for referral/presenting concern:

Many thanks for your referral