THE MASSAGE CLINIC
HEALTH CENTRES

Massage Therapy - Intake Form

Contact Information

Please Circle: Mr. Mrs. Miss Ms. Dr. Sir

Name:________________________ Address:________________________

City:____________________ Province:______________ Postal Code:__________

Phone # Home:______________ Work:______________ Cell:______________

Email:________________________ Date of Birth: Day______ Month______ Year______

Gender (please circle) Male Female

Occupation:______________ Hrs/week:_____ Work Posture:______________

Emergency Contact Name:______________Phone #:__________Relationship:__________

Medical Doctor:______________Address:______________Phone:______________

How did you hear of our office?____

Medical Information

What is your primary complaint?____

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Are you currently receiving treatment from any of the following practitioners? (Please check all that apply)

- ☐ Massage Therapist
- ☐ Chiropractor
- ☐ Physiotherapist
- ☐ Osteopathic Manual Practitioner
- ☐ Naturopathic Doctor/Acupuncturist
- ☐ Athletic Therapist

Have you received treatment in the past for massage therapy, physiotherapy, chiropractic care, etc.? (Please circle) **Yes / No**

How is your general health?____

Are you currently taking any medications? (Please circle) **Yes / No**

If yes, please list them: ____

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Please list any current or previous injuries you have experienced (if applicable): ______________________

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Please list any surgeries you have had (if applicable):______________________________

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Patient Conditions

Please check off all that apply.

	Family History						
	Arthritis		Cardiovascular		Respiratory		
	Area of Complaint						
	Abdomen		Chest		Left Ankle		Left Arm
	Left Elbow		Left Foot		Left Hand		Left Hip
	Left Knee		Left Leg		Left Shoulder		Left Side of Low Back
	Left Side of Mid Back		Left Side of Neck		Left Side of Upper Back		Left Wrist
	Right Ankle		Right Arm		Right Elbow		Right Foot
	Right Hand		Right Hip		Right Knee		Right Leg
	Right Shoulder		Right Side of Low Back		Right Side of Mid Back		Right Side of Neck
	Right Side of Upper Back		Right Wrist				
	Headaches						
	Chronic Daily Headache		Cluster		Headaches		Migraines
	Rebound		Sinus		Tension		
	Blood						
	Anemia		Bleeding Disorder		Haemophilia		Hepatitis
	Thrombosis/Embolism		HIV/AIDS		Hypercoagulability		Polycythemia
	Cardiovascular						
	Acute Coronary Syndrome		Aneurysm		Angina		Atherosclerosis
	Blood Clots		Cardiac Arrhythmia		Cardiovascular Accident		Cardiovascular Conditions
	Chronic Ischemic Heart Disease		Chronic Venous Insufficiency		Cold Feet		Cold Hands
	Congenital Heart Defect		Congestive Heart Failure		Coronary Artery Disease		Heart Attack
	Heart Disease		High Blood Pressure		Hyperlipidemia		Low Blood Pressure
	Lymphedema		Myocardial Infarction		Pacemaker		Pericarditis
	Phlebitis		Raynaud Disease		Rheumatic Heart Disease		Valve Disorders
	Varicose Veins						
	Emotion & Memory						
	Alzheimer Disease		Anxiety Disorder		Mood Disorder		Schizophrenia
	Stress		Substance Use Disorder				
	Endocrine						
	Acute Pancreatitis		Diabetes		Hyperthyroidism		Hypothyroidism
	Pituitary and Growth Disorder						
	Gastrointestinal						
	Celiac Disease		Constipation		Crohn’s Disease		Diarrhea
	Digestive Conditions		Diverticulitis		Eating Disorder		Esophageal Disorder
	Fecal Impaction		Intestinal Polyps		Irritable Bowel Syndrome		Poor Appetite
	Stomach Disorder		Ulcerative Colitis				
	Hearing						
	Conductive Hearing Loss		Ear Problems		Hearing Loss		Meniere Disease
	Motion Sickness		Tinnitus		Vertigo		
	Immune						
	Allergies		Anaphylaxis		Cancer		Hodgkin Lymphoma
	Infectious Mononucleosis		Leukemia		Lupus		Non-Hodgkin Lymphoma
	Rheumatoid Arthritis						

Kidney							
	Bladder Disorder		Chronic Kidney Disease		Congenital Kidney Disease		Electrolyte Imbalance
	Kidney Stones		Renal Cysts		Urinary Incontinence		Urinary Tract Infection
Musculoskeletal							
	Amyotrophic Lateral Sclerosis (ALS)		Ankylosing Spondylitis		Arthritis		Artificial Joints/Special Equipment
	Bone Disease		Compartment Syndrome		Dislocation		Fibromyalgia
	Fracture		Gout		Hereditary/Congenital Deformity		Jaw Pain (TMJD)
	Joint Injury		Muscular Dystrophy		Myasthenia Gravis		Osgood-Schlatter Disease
	Osteoarthritis		Osteomalacia		Osteoporosis		Paget Disease
	Psoriatic Arthritis		Scleroderma		Scoliosis		Sinus Problems
	Strain/Sprain		Sciatica		Bulged Disc		Herniated Disc
Neurological							
	Brain Disorder		Brain Injury		Burning		Cerebral Palsy
	Cerebral Vascular Accident (Stroke)		Cerebral-Vascular Accident		Chronic Pain Disorder		Dizziness
	Epilepsy		Herniated Disc		Huntington Disease		Loss of Sensation
	Multiple Sclerosis		Numbness		Parkinson's		Seizure Disorder
	Shingles		Stabbing		Stroke		Tingling
	Transient Ischemic Attacks (TIA)		Vertebral and Spinal Cord Injury				
Reproductive							
	Breast Disorder		Ectopic Pregnancy		Endometriosis		Gynaecological Conditions
	Menopause		Menstrual Cycle Disorder		Ovarian Cysts/Tumors		Pelvic Inflammatory Disease
	Pregnancy		Premenstrual Syndrome		Uterine Disorder		
Respiratory							
	Asthma		Bronchitis		Chronic Cough		COPD
	Cystic Fibrosis		Emphysema		Infectious Respiratory Conditions		Respiratory Conditions
	Respiratory Tract Infection		Shortness of Breath				
Skin							
	Acne		Allergic Dermatosis		Athlete's Foot		Rash
	Bruise Easily		Chemical Burn		Herpes		UV Burn
	Hypersensitive Reactions		Infectious Skin Conditions		Melanoma/Carcinoma		Pigmentary Disorder
	Skin Irritations		Plantar's Wart		Psoriasis		Skin Conditions
	Rosaceea						
Miscellaneous							
	Insomnia		Mental Illness		Other Diagnosed Diseases		Other Medical Conditions
	Surgical Pins or Wire		Vision Loss		Vision Problems		