MASSAGE THERAPY PATIENT INTAKE FORM

DATE

PATIENT INFORMATION

FIRST NAME | INT | LAST NAME | EMAIL (OPTIONAL)

ADDITIONAL INFORMATION

DATE OF BIRTH (DD MM YY) | AGE | GENDER

CONTACT INFORMATION

HOME PHONE | WORK PHONE | EXT | CELL PHONE

STREET NUMBER AND NAME | CITY

PROVINCE | COUNTRY | POSTAL CODE

EMERGENCY CONTACT

EMERGENCY CONTACT NAME | RELATION | EMERGENCY PHONE

PATIENT HISTORY

OCCUPATION | SOURCE OF REFERRAL | CURRENT TREATMENT WITH OTHER PRACTIONERS

PRIMARY COMPLAINT

PAST TREATMENT WITH OTHER PRACTIONERS | GENERAL HEALTH

FAMILY PHYSICIAN INFORMATION

FAMILY PHYSICIAN | PHYSICIAN ADDRESS | PHONE NUMBER (IF KNOWN) | CAN WE CONTACT THEM ☐ YES ☐ NO

In keeping with the Health Care Consent Act 1996, it is my choice to receive a therapeutic massage. It is also my understanding that the information I provided above is confidential and it will not be released without my permission.

I am aware that it is not necessary to remove all articles of clothing for a therapeutic massage, and I will only remove the clothing that I am comfortable with. I am aware that I may experience possible side effects from the therapeutic massage such as; temporary discomfort within the muscles (24 - 48 hours post therapeutic massage treatment), bruising and temporary dizziness.

I understand that massage practitioners do not diagnose illness, disease, or any physical or mental disorder; nor do they prescribe medical treatment, pharmaceuticals, or perform spinal thrust manipulations. I acknowledge that massage is not a substitute for medical examination or diagnosis, and that it is recommended that I see a primary health care provider for that service.

I have stated all medical conditions that I am aware of and will update the massage practitioner of any changes in my health status. Cancellation requires 24 hr notice or fee may be charged at the discretion of the Therapist . Missed appointments will be charged a full fee.

Signature (parent or guardian if under 18 years

Date

PLEASE TURN PAGE OVER

KGC THERAPY
1575 UPPER OTTAWA ST, HAMILTON ONTARIO L8W 3E2

MASSAGE THERAPY

PATIENT INTAKE FORM

PATIENT CONDITIONS

RESPIRATORY

☐ ASTHAMA	☐ BRONCHITIS	☐ CHRONIC COUGH	☐ EMPHYSEMA
☐ SHORTNESS OF BREATH			

CARDIOVASCULAR

☐ BLOOD CLOTS	☐ CARDIOVASCULAR ACCIDENTS	☐ CEREBROVASCULAR ACCIDENT	☐ COLD FEET
☐ COLD HANDS	☐ CONGESTIVE HEART FAILURE	☐ HEART ATTACK	☐ HEART DISEASE
☐ HIGH BLOOD PRESSURE	☐ LOW BLOOD PRESSURE	☐ LYMPHEDEMA	☐ MYOCARDIAL INFARCTION
☐ PACEMAKER	☐ PHLEBITIS	☐ STROKE	☐ THROMBOSIS/EMBOLISM
☐ VARICOSE VEINS			

SKIN

☐ BRUISE EASILY	☐ HYPERSENSITIVE REACTION	☐ MELANOMA	☐ SKIN CONDITIONS
☐ SKIN IRRITATION			

HEAD AND NECK

☐ EAR PROBLEMS	☐ HEADACHES	☐ HEARING LOSS	☐ JAW PAIN (TMJ)
☐ MIGRAINES	☐ SINUS PROBLEMS	☐ VISION LOSS	☐ VISION PROBLEMS

INFECTIOUS CONDITIONS

☐ ATHLETE'S FOOT	☐ HEPATITIS	☐ HERPES	☐ HIV
☐ RESPIRATORY CONDITIONS	☐ SKIN CONDITION		

WOMEN

☐ GYNECOLOGICAL PROBLEMS	☐ PREGNANCY		

SOFT TISSUE/JOINT DYSFUNCTION

☐ ANKLES (LEFT)	☐ ANKLES (RIGHT)	☐ ARMS (LEFT)	☐ ARMS (RIGHT)
☐ FEET (LEFT)	☐ FEET (RIGHT)	☐ HANDS (LEFT)	☐ HANDS (RIGHT)
☐ HIPS (LEFT)	☐ HIPS (RIGHT)	☐ KNEES (LEFT)	☐ KNEES (RIGHT)
☐ LEGS (LEFT)	☐ LEGS (RIGHT)	☐ LOW BACK (LEFT)	☐ LOW BACK (RIGHT)
☐ MID BACK (LEFT)	☐ MID BACK (RIGHT)	☐ NECK (LEFT)	☐ NECK (RIGHT)
☐ SHOULDERS (LEFT)	☐ SHOULDERS (RIGHT)	☐ UPPER BACK (LEFT)	☐ UPPER BACK (RIGHT)

FAMILY HISTORY

☐ CARDIOVASCULAR CONDITIONS	☐ RESPIRATORY CONDITIONS		

MISCELLANEOUS

☐ ALLERGIES	☐ ANAPHYLAXIS	☐ ARTIFICIAL JOINTS/SPECIAL EQUIPMENT	☐ ARTHRITIS
☐ CANCER	☐ CROHN'S DISEASE	☐ DIABETES	☐ DIGESTIVE CONDITIONS
☐ DIZZINESS	☐ EPILEPSY	☐ FIBROMYALGIA	☐ GOUT
☐ HAEMOPHILIA	☐ INSOMNIA	☐ LOSS OF SENSATION	☐ LUPUS
☐ MENTAL ILLNESS	☐ OSTEOARTHRITIS	☐ OSTEOPOROSIS	☐ OTHER DIAGNOSED CONDITIONS
☐ OTHER MEDICAL CONDITIONS	☐ RHEUMATOID ARTHRITIS	☐ SHINGLES	☐ STRESS
☐ SURGICAL PINS OR WIRES			

NEUROLOGICAL

☐ BURNING	☐ CEREBRAL PALSY	☐ HERNIATED DISC	☐ MULTIPLE SCLEROSIS
☐ NUMBNESS	☐ PARKINSONS	☐ STABBING	☐ TINGLING

ADDITIONAL INFORMATION

MEDICATIONS

INJURIES

SURGERIES

ANNUAL REVIEW OF ABOVE HEALTH HISTORY

	DATE	CLIENT	THERAPIST
☐			
☐			
☐			

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