Client Intake and Health History

DATE: ______________________________

An accurate health history ensures that it is safe for you to receive a massage treatment, helping your therapist determine a proper treatment plan. If and when your health status changes in the future, please let us know. All information gathered on this form is confidential. Unless otherwise stated, your written authorization is legally required before any of this information can be released.

Name in Full: ____

Address: ____

City/Prov ____________________Postal Code___________ Home Phone: ___________Cell Phone: ___________

Email: _______________________ Occupation: ___________________Date of Birth: _______________

Emergency Contact: _______________ Phone: ________________ Relationship: __________

For Insurance Billing Purposes *(completion and submission of this information and form ahead of your appointment time will permit early creation of your Insurance Billing Account for Direct Billing purposes)*, **please provide:**

Spouses Full Name________________________________ Spouses Date of Birth ________________

Insurance Provider (GWL, Blue Cross etc): ____

Identification Number (Policy) ____________________ Policy Number _________________________

Is a Doctors Referral Required? If so, please provide a copy of the referral upon attendance.

Doctors Name: ______________________ Address: __________________________________

Phone: ________________

Other Health Care Professionals Being Used:

____

May we contact your physician or other health care providers in regards to your health care? □ yes □ no

Major complaint: ____

Key:
Circle the area on your body where you have stiffness, muscle aches, pain, or discomfort.

What makes the condition worse? ____
What makes the condition better? ____
Have you had this condition in the past? □ yes □ no If yes, was it resolved?: □ yes □ no

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Cardiovascular System

☐ aneurysm
☐ high blood pressure/hypertension
☐ low blood pressure/hypotension
☐ heart disease
☐ stroke
☐ varicose veins
☐ phlebitis
☐ bruise easily
☐ pacemaker

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Nervous System

☐ multiple sclerosis
☐ Parkinson's
☐ seizures/epilepsy
☐ carpal tunnel
☐ altered/loss of sensation
Specify areas:
____
____
____

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Medications

Please indicate type, what it is for and the times that it is taken:
____
____
____
____
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____
____

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Digestive Systems

☐ ulcers
☐ constipation
☐ ulcerative colitis
☐ Crohn's disease
☐ gall stones
☐ irritable bowel syndrome (IBS)
☐ liver disease
Other (specify):

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Skin

☐ plantar warts
☐ eczema
☐ psoriasis
☐ fungal infection (ex. athlete's foot)
☐ herpes simplex
Other (specify):
____
____
____

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Respiratory Systems

☐ bronchitis
☐ asthma
☐ emphysema
☐ sinusitis
☐ chronic cough
☐ breathing problems
Specify:
____
____

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Head/Neck

☐ history of headaches
☐ history of migraines
☐ vision problems or loss
☐ hearing/ear problems
☐ dizziness

Women

☐ menopausal problems
☐ painful menstruation
☐ pregnant
Due date:
____
____
☐ caesarean section
☐ endometriosis
Other (specify):
____
____

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Other Conditions

☐ hepatitis
☐ HIV/AIDS
☐ diabetes
☐ chronic fatigue syndrome
☐ environmental illness
☐ allergies
Specify:
____
____
____
☐ tumours/cysts
☐ cancer
Specify:
____
____
____
Other (specify):
____

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Muscles and Joints

☐ fibromyalgia
☐ osteoporosis
☐ arthritis
Specify type and location:
____
____
____
☐ pain/stiffness:
  ☐ head
  ☐ neck
  ☐ jaw
  ☐ back
    ☐ Lower
    ☐ Middle
    ☐ Upper
  ☐ arm/hand
  ☐ leg/foot

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Other Healthcare

☐ physician/medical doctor
☐ chiropractor
☐ massage therapist
☐ physiotherapist
☐ naturopathic doctor
☐ nutritionist/dietician
Other (specify):
____

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Surgeries

Please indicate type, area(s) and date of surgery:
____
____
____
____
____
____

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Previous Injuries

Please indicate area(s), date of injury and a brief description of what happened:
____
____
____
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By my signature below, I authorize that all of the information is provided to the best of my knowledge. I understand that all of my personal information is confidential and will be treated in accordance with the Privacy Act.

Please allow 24 hours notice for cancellation of appointments. There will be a fee for any appointments missed

Signature: ____ Date: ___________________________________