



BACK & BODY HEALTH

PDF Intake Form Directions

Due to the sensitive nature of the information required, you cannot send these forms via e-mail.

Please print off your intake form, complete it and bring with you to your appointment. Alternatively, you can fax it to us at: 403.245.9030.

If you have any questions please call us:
Tel: 403.209.BACK (2225)



BACK & BODY HEALTH

MASSAGE THERAPY
PATIENT ADMITTANCE FORM

PERSONAL INFORMATION

Name:		Today's Date (mm/dd/yyyy):	
Date of Birth (mm/dd/yyyy):	Age:	Gender:	Female Male
Address:			
City:	Province:	Postal Code:	
Home Phone:	Business Phone:		
Your Occupation:	Employer:		

In case of emergency, whom should we notify?	
Relation to you?	Contact Number:

Family Doctor:	Contact Number:
Permission to consult with family doctor: Yes No	
Permission for correspondence through: Mail Occasion cards	E-mail address:

How did you hear about our office: Doctor Health Care Prof. Friend Phone Book Sign Internet
Other: If you circled friend who can we thank?

REASON FOR APPOINTMENT

What is your chief complaint?

Describe the onset:

Provide the primary symptoms and rate them mild, moderate or severe:

Using an "X", please rate your pain on the line below

No pain _____ Very Painful

Is this a car accident case? Yes No	Have you recently been in an accident? Yes No
*** If YES, please fill out Notice of loss & Proof of Claim (formAB-1) and MVA form ***	

Have you seen any other physician or health care professional for this complaint? Yes No	
If YES, Doctor's name:	Date of last treatment:
Diagnosis:	What type of treatment did you receive?

List current medication, including aspirin, ibuprophen, antihistamines, birth control etc. and their purpose:

Do you suffer from headaches? Yes No	How often?
How long do they last?	

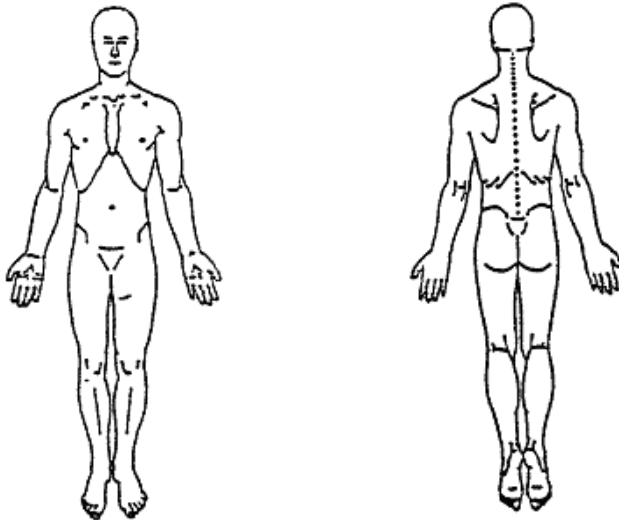


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Mark the area(s) of pain or unusual feelings using the appropriate symbols *****To be completed at time of arrival*****

- Circle areas of PAIN
- 'X' over the areas of JOINT AND MUSCLE STIFFNESS
- Draw squiggly lines along the areas of NUMBNESS, TINGLING OR ALTERED SENSATION
- Additional comments:



HEALTH HISTORY

Please check the appropriate box of any of the following symptoms that you now have or have had previously

***** IF THE SYMPTOM IS NOT APPLICABLE TO YOU, PLEASE LEAVE BLANK *****

C = Constant

F = Frequent

O = Occasional

C	F	O	C	F	O	C	F	O
MUSCLE & JOINT			RESPIRATORY			GENITO-URINARY		
		Tendonitis	Yes		Chronic cough		Yes	Kidney Infection
		Bursitis	Yes		Asthma			Pregnant
		Broken / Fractured bones	Yes		Allergies			Months:
		Sprains / Strains			Type:	GASTRO INTESTINAL		
		Low back / hip / leg pain	NERVOUS SYSTEM				Yes	Constipation
		Neck / shoulder / arm pain			Numbness / tingling			Digestive Problems
		Spasms / Cramps			Herpes / Shingles	OTHER		
Yes		Bone or Joint disease			Fatigue	Yes		Poor Nutrition
Yes		Arthritis	Yes		Chronic Pain	Yes		Drug / Alcohol
Yes		Flat feet / High arches	CARDIO-VASCULAR			Yes		Caffeine
SKIN			Yes		Heart condition	Yes		Epilepsy/ Seizures
		Dryness	Yes		Varicose veins	Yes		Cancer / Tumors
		Skin rash	Yes		Blood clots			Type:
		Athletes Foot	Yes		High blood pressure	Yes		Diabetes
		Warts	Yes		Low blood pressure			Type:
Yes		Bruise easily	Yes		Lymphedema	Yes		Mental health
Yes		Hives or allergy	Yes		Hemophilia			Type:
Yes		Acne/Open Wounds/Sores	Yes		Stroke	Yes		Infectious Disease
		Location:	Yes		Arteriosclerosis			Type:



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Surgery / Injury:

Accidents:

Other medical conditions:

WAIVER

I have stated all medical conditions that I am aware of and will update the massage practitioner of any changes in health status. I agree to immediately inform the therapist if I experience any pain or discomfort during my massage so that the pressure and/or strokes may be adjusted to my level of comfort. I also agree to request the massage therapist to stop treatment if I feel like my well-being is being compromised in any way. I assume all risks and responsibilities for myself and release Back & Body Health and the therapist from responsibility from any injury or liability that may occur during a treatment session.

Signature:

Date (mm/dd/yyyy):

***** Please leave blank – To be signed at time of arrival *****