

BACK & BODY HEALTH
CALGARY MASSAGE CLINIC
MASSAGE THERAPY INTAKE FORM

PERSONAL INFORMATION		
Name:	Today's Date (mm/dd/yyyy):	
Date of birth (mm/dd/yyyy)	Age:	Gender:
Address		
City:	Province:	Postal Code:
Home/Cell Phone:	Work Phone:	
Your occupation:	Employer:	
E-mail address:		
Permission for correspondence through	<input type="checkbox"/> Phone <input type="checkbox"/> Mail <input type="checkbox"/> Occasion cards <input type="checkbox"/> E-mail <input type="checkbox"/> Other:	

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

Family Doctor:	Contact Number:
Permission to consult with family doctor	<input type="checkbox"/> Yes <input type="checkbox"/> No

How did you hear about our office	<input type="checkbox"/> Health Care Prof. <input type="checkbox"/> Friend <input type="checkbox"/> Sign <input type="checkbox"/> Internet <input type="checkbox"/> Other: _____
If you checked friend who can we thank:	

REASON FOR APPOINTMENT
What is your chief complaint?
Describe the onset
Provide the primary symptoms. Rate the symptoms mild, moderate or severe

Using an "X", please rate your pain on the line below		
No Pain	_____	Very Painful
1	5	10

Is this a car accident case	<input type="checkbox"/> Yes <input type="checkbox"/> No	Have you recently been in an accident	<input type="checkbox"/> Yes <input type="checkbox"/> No
*** If YES, please fill out Notice of loss & Proof of Claim (form AB-1) and MVA form ***			

Have you seen any other physician or health care professional for this complaint <input type="checkbox"/> Yes <input type="checkbox"/> No	
If YES, Doctors Name:	Date of last treatment:
Diagnosis:	What type of treatment did you receive:

Were you medically cleared for treatment? <input type="checkbox"/> Yes <input type="checkbox"/> No	
List current medications, including aspirin, ibuprofen, antihistamines, birth control etc. and their purpose:	
Do you suffer from headaches: <input type="checkbox"/> Yes <input type="checkbox"/> No If yes how often?	
How long do they last?	

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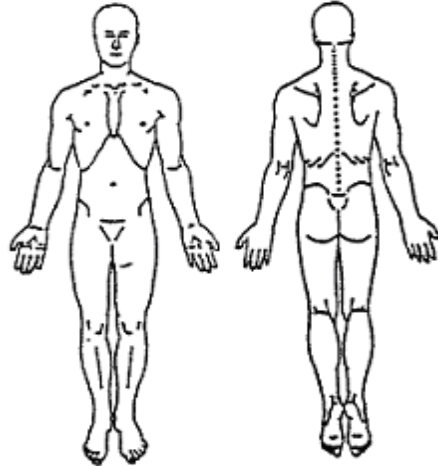
Mark the area(s) of pain or unusual feeling using the appropriate symbols.

▪ Circles area 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
<p>MUSCLE & JOINT</p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Tendonitis</p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Bursitis</p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Broken / Fractured bones</p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Sprains / Strains</p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Low back / hip / leg pain</p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Neck / shoulder / arm pain</p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Spasms / cramps</p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Jaw pain / TMJ</p> <p>Do you have:</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No Bone or Joint disease</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No Arthritis</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No Flat feet / High arches</p> <p>SKIN</p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Dryness</p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Skin rash</p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Athletes foot</p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Warts</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No Bruise easily</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No Hives or allergy</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No Acne / open wounds / sores</p> <p>Location:</p>	<p>RESPIRATORY</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No Chronic cough</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No Asthma</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No Allergies</p> <p>Type:</p> <p>NERVOUS SYSTEM</p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Numbness / Tingling</p> <p>Location:</p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Herpes / Shingles</p> <p>Location:</p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Fatigue</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No Chronic pain</p> <p>CARDIO-VASCULAR</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No Heart condition</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No Varicose veins</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No Blood clots</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No High blood pressure</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No Low blood pressure</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No Lymphedema</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No Hemophilia</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No Stroke -When_____</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No Arteriosclerosis</p>	<p>GENITO-URINARY</p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Kidney infection</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No Pregnant: #Months ___</p> <p>GASTRO-INTESTINAL</p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Constipation</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No Digestive problems</p> <p>OTHER – Do you have/take</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No Poor nutrition</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No Drugs/medication</p> <p>Type:</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No Alcohol: # per week ___</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No Caffeine cups per day___</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No Epilepsy</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No Cancer / tumors</p> <p>Type:</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No Diabetes Type:</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No Mental Health</p> <p>Type:</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No Infectious disease</p> <p>Type:</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No Concussion Symptoms</p>

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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 the Massage Therapist and Back & Body Health from responsibility from any injury or liability that may occur during a treatment session.

Signature

Date