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Central Health Care

Registered Massage Therapy

Confidential Patient Intake Form

The information requested below will assist us in treating you safely. Feel free to ask any questions about the information being requested. Please note that all information provided below will be kept confidential unless allowed or required by law. Your written permission will be required to release any information outside this clinic.

Today's Date (D/M/Y):			
Name:		Date of Birth (D/M/Y):	Age:
Address:		City:	Postal Code:
Home Ph.	Cell Ph.	Business Ph.	Ext.
Email: May we send you emails about important office notifications including appointment reminders and statements? □ Yes □ No		☐ Male ☐ Female	Height: / Weight:
Occupation:		Employer:	
Medical Doctor's Name:	Phone:	City:	
Emergency Contact:	Relationship:	Phone:	
Prior Massage Therapy? ☐ Yes ☐ No	Reason: ☐ Relaxation ☐ Medical		
What is your primary concern? Have you had this condition in the past? ☐ Yes ☐ No	Did you receive treatment for this in the past? ☐ Yes ☐ No If Yes what type of treatment did you receive?		
☐ Work related injury / accident (WSIB) Date of accident: _____ Claim Number: _____ ☐ Motor vehicle accident (MVA) Date of accident: _____			
How did you hear about our office? ☐ Family doctor ☐ Family / Friend ☐ Yellow Pages ☐ Internet ☐ Other _____			

- I understand that massage therapy involves the manipulation of soft tissues and joints of the body in order to develop, maintain, rehabilitate, improve physical function, or relieve pain.
- I understand that during a massage treatment the massage therapist will, to the best of his/her ability, undrape only the area to be massaged, providing the draping, comfort, warmth, security, and privacy as requested.
- I consent to a massage and I understand that I can change or terminate my treatment at any time.
- I also understand that I am responsible for any charges incurred in the course of my treatment.
- I understand that 24 hour notice is required to reschedule all future appointments, or full charges will apply.

Signature: _____ **Date:** _____

Please note this is a multi-disciplinary clinic. This is to confirm that I give my consent to allow the other massage therapists at Central Health Care to access the information in my file and administer treatment should it be required.

Patient Initials: _____

806 Gordon St. Guelph ON N1G1Y7

Health History: Please check ☑ conditions you are experiencing or have experienced in the past

SKIN

- ☐ Rashes / bruise easily
- ☐ Contagious skin conditions
- ☐ Allergies
- ☐ Infectious skin conditions
- ☐ Other: _____

HEAD / NECK

- ☐ Visual impairment
- ☐ Hearing impairment
- ☐ Hearing Aid
- ☐ Speech impairment
- ☐ Sinus problems
- ☐ Jaw pain (TMJ pain)
- ☐ Headache / migraine

RESPIRATORY

- ☐ Asthma
- ☐ Bronchitis
- ☐ Chronic cough
- ☐ Emphysema
- ☐ Difficult breathing
- ☐ Shortness of breath
- ☐ Smoking
- ☐ Other: _____

CARDIOVASCULAR

- ☐ High / low blood pressure
  BP: _____ / _____
- ☐ Bleeding disorder
- ☐ Hemophilia
- ☐ Arteriosclerosis
- ☐ Heart attack
- ☐ Angina
- ☐ Stroke / cerebrovascular accident
- ☐ Pacemaker / internal defibrillator
- ☐ Varicose veins
- ☐ Phlebitis
- ☐ Poor circulation
- ☐ Other: _____

MUSCLES / JOINTS *Please indicate the right or left side where appropriate*

- ☐ Upper back R L
- ☐ Mid back R L
- ☐ Lower back R L
- ☐ Shoulders R L
- ☐ Elbows R L
- ☐ Arm R L
- ☐ Neck R L
- ☐ Wrist R L
- ☐ Hand R L
- ☐ Hip R L
- ☐ Leg R L
- ☐ Knee R L
- ☐ Ankle R L
- ☐ Foot R L
- ☐ Weakness / loss of strength
- ☐ Clumsiness
- ☐ Multiple sclerosis
- ☐ Osteoarthritis
- ☐ Rheumatoid arthritis
- ☐ Tendonitis
  Location: _____
- ☐ Strain
  Location: _____
- ☐ Joint sprain / dislocation
  Location: _____
- ☐ Artificial joints / pins / wires / screws
  Location: _____
- ☐ Orthotics

GI CONDITIONS

- ☐ Constipation
- ☐ Diarrhea
- ☐ Irritable Bowel
- ☐ Other: _____

INFECTIOUS CONDITIONS

- ☐ Herpes / STDs
- ☐ Hepatitis: _____
- ☐ HIV / AIDS
- ☐ Tuberculosis (TB)
- ☐ Other: _____

OTHER CONDITIONS

- ☐ Allergies
- ☐ Cancer
- ☐ Diabetes
- ☐ Fainting
- ☐ Fever
- ☐ Insomnia
- ☐ Numbness / tingling
  Where? _____

PAST FRACTURES OR SURGERIES

Fracture ☐ Yes ☐ No **Date :** _____
Car accident ☐ Yes ☐ No **Date :** _____
Surgery ☐ Yes ☐ No **Date :** _____
For? _____

WOMEN

- ☐ Pregnant? Due: _____
  No. of children: _____
- ☐ Menstrual difficulties
- ☐ Gynecological conditions: _____

MEDICATIONS

Please list all medications, natural remedies, supplements, etc.

OFFICE USE ONLY

Health History Updates / Changes

Date: _____ Change: _____ Initial: _____
Date: _____ Change: _____ Initial: _____
Date: _____ Change: _____ Initial: _____
Date: _____ Change: _____ Initial: _____

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