AIRDRIE FAMILY WELLNESS

MASSAGE THERAPY INTAKE

PERSONAL INFORMATION:

FIRST NAME: _____ LAST NAME: _____

ADDRESS: _____ CITY: _____ PROV: _____ POSTAL CODE: _____

PHONE: (H): _____ (W): _____ (C): _____

E-MAIL: _____ (USED ONLY FOR CLINIC COMMUNICATION)

D.O.B: _____/_____/_____ (MM/DD/YYYY) MARITAL STATUS: _____ CHILDREN? ☐ YES ☐ NO

OCCUPATION: _____ EMPLOYER: _____

PHYSICIAN: _____ EMERGENCY CONTACT: _____

ARE YOU RECEIVING TREATMENT FROM OTHER HEALTH CARE PROFESSIONALS? (PLEASE CHECK ALL THAT APPLY)

☐ CHIROPRACTIC ☐ ACUPUNCTURE ☐ PHYSIOTHERAPY ☐ OTHER: _____

HAVE YOU HAD MASSAGE THERAPY BEFORE? ☐ YES ☐ NO

WHAT TYPE OF MASSAGE TREATMENT ARE YOU LOOKING FOR? (PLEASE CHECK ALL THAT APPLY)

☐ WELLNESS ☐ DEEP TISSUE ☐ PAIN RELIEF ☐ RELAXATION ☐ SPORT ☐ OTHER: _____

HOW DID YOU HEAR ABOUT OUR CLINIC?

☐ SIGN ☐ INTERNET ☐ PHONEBOOK ☐ OTHER: _____ ☐ PERSON: _____

MEDICAL HISTORY:

PLEASE INDICATE THE FOLLOWING: (CHECK MARK FOR CURRENT, UNDERLINE FOR PAST)

MUSCULOSKELETAL:
- ☐ ARTHRITIS
- ☐ OSTEOPOROSIS
- ☐ SCOLIOSIS
- ☐ FIBROMYALGIA
- ☐ BROKEN/FRACTURED BONES
- ☐ SPRAINS/STRAINS
- ☐ MUSCLE CRAMPS/SPASMS
- ☐ WHIPLASH
- ☐ TENDONITIS
- ☐ BURSITIS
- ☐ TMJ DYSFUNCTION

NERVOUS SYSTEM:
- ☐ EPILEPSY
- ☐ MULTIPLE SCLEROSIS
- ☐ PARKINSON'S DISEASE
- ☐ NERVE DAMAGE
- ☐ OTHER: _____

CIRCULATORY:
- ☐ HEART DISEASE
- ☐ HEART ATTACK
- ☐ LOW BLOOD PRESSURE
- ☐ HIGH BLOOD PRESSURE
- ☐ STROKE
- ☐ ANEURISM
- ☐ VARICOSE VEINS
- ☐ DEEP VEIN THROMBOSIS
- ☐ BLOOD CLOTS
- ☐ POOR CIRCULATION
- ☐ BRUISE EASILY
- ☐ OTHER: _____

RESPIRATORY:
- ☐ ASTHMA
- ☐ CHRONIC OBSTRUCTIVE PULMONARY DISEASE
- ☐ BRONCHITIS
- ☐ ALLERGIES
- ☐ SINUS PROBLEMS
- ☐ OTHER: _____

SKIN:
- ☐ RASHES
- ☐ ALLERGIES
- ☐ SENSITIVE SKIN
- ☐ ATHLETE'S FOOT
- ☐ WARTS
- ☐ OTHER: _____

DIGESTIVE:
- ☐ IRRITABLE BOWEL SYNDROME
- ☐ CROHN'S DISEASE
- ☐ COLITIS
- ☐ ULCERS
- ☐ HYPOGLYCEMIA
- ☐ OTHER: _____

OTHER:
- ☐ CANCER/TUMORS
- ☐ DIABETES
- ☐ KIDNEY DISEASE
- ☐ LIVER DISEASE
- ☐ FIBROMYALGIA
- ☐ INFECTIOUS DISEASE (HIV/AIDS, HEPATITIS)
- ☐ VISION OR HEARING LOSS
- ☐ HERNIA
- ☐ HEADACHE/MIGRAINE
- ☐ TINGLING/NUMBNESS
- ☐ DEPRESSION
- ☐ ANXIETY

FOR FEMALES:
- ☐ MENSTRUAL PAIN/CRAMPING

PREGNANT? ☐ YES ☐ NO ☐ UNSURE

HOW MANY WEEKS? _____

PLEASE LIST ALL MEDICATIONS YOU ARE CURRENTLY TAKING: _____

_____

PLEASE LIST ALL SURGERIES YOU HAVE HAD AND THEIR DATES: _____

_____

CURRENT COMPLAINT:

ARE YOU SEEKING TREATMENT AS A RESULT OF A MOTOR VEHICLE ACCIDENT (MVA)? ☐ YES ☐ NO

IF YES, PLEASE SPECIFY: _____

INSURANCE COMPANY: _____CLAIM #: _____

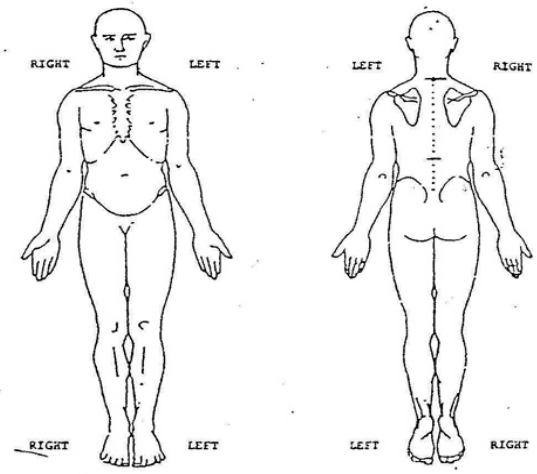
ADJUSTER: _____ DATE OF ACCIDENT: _____/_____/_____ (MM/DD/YYYY)

ARE YOU SEEKING TREATMENT AS A RESULT OF A WORK INJURY (WCB)? ☐ YES ☐ NO

IF YES, PLEASE SPECIFY: _____

(PLEASE NOTE THAT WCB DOES NOT COVER MASSAGE THERAPY)

PLEASE INDICATE YOUR SYMPTOMS ON THE DIAGRAM BELOW:



LEGEND:

++++	ACHINESS
XXXX	BURNING
////	STABBING
====	TINGLING
####	NUMBNESS

PAIN SCALE (PLEASE CIRCLE):

1—2—3—4—5—6—7—8—9—10

INFORMED CONSENT:

I UNDERSTAND THAT THE MASSAGE THERAPY PROVIDED AT AIRDRIE FAMILY WELLNESS IS NOT A SUBSTITUTE FOR MEDICAL TREATMENT, AND THAT IT IS RECOMMENDED THAT I CONCURRENTLY WORK WITH MY PRIMARY CAREGIVER FOR ANY CONDITION I MAY HAVE. I AM AWARE THAT THE MASSAGE THERAPIST DOES NOT DIAGNOSE ILLNESS OR DISEASE, DOES NOT PRESCRIBE MEDICATIONS, AND DOES NOT USE SPINAL MANIPULATIONS AS PART OF THE THERAPY.

I ACKNOWLEDGE AND UNDERSTAND THAT THE MASSAGE THERAPIST MUST BE FULLY AWARE OF MY EXISTING MEDICAL CONDITIONS. I HAVE COMPLETED MY MEDICAL HISTORY FORM AND DISCLOSED TO THE MASSAGE THERAPIST ALL OF THOSE MEDICAL CONDITIONS AFFECTING ME. IT IS MY RESPONSIBILITY TO KEEP THE MASSAGE THERAPIST UPDATED ON MY MEDICAL HISTORY. THE INFORMATION I HAVE PROVIDED IS TRUE AND COMPLETE TO THE BEST OF MY KNOWLEDGE.

I HEREBY RELEASE THE MASSAGE THERAPIST FROM ANY AND ALL LIABILITY FROM PROBLEMS ARISING FROM ANY TREATMENT AS A RESULT OF INFORMATION NOT GIVEN OR GIVEN INCORRECTLY IN THIS MASSAGE INTAKE FORM.

I UNDERSTAND THAT PAYMENT IS EXPECTED AT THE TIME OF TREATMENT UNLESS PREVIOUS ARRANGEMENTS HAVE BEEN MADE WITH THE MASSAGE THERAPIST. I UNDERSTAND THAT IF I FAIL TO CANCEL AN APPOINTMENT **12 HOURS** IN ADVANCE I WILL BE CHARGED A FEE OF **50%** OF THE MISSED APPOINTMENT TIME.

_____ _____

SIGNATURE (PARENT/GUARDIAN IF UNDER 18 YEARS OF AGE) DATE

_____

PRINT NAME