Deidre Comeau RMT
Wellness Clinic
Mount Uniacke NS

MASSAGE THERAPY
client intake form

First Name: Last Name:

Date of birth: Referred by:

Address:

City: Postal Code:

Email Address:

Mobile Phone: Home Phone:

Emergency Contact Name: Emergency Phone:

Physician's Name: Physicians's Phone:

Date of Initial Visit:

MEDIACL HISTORY

How would you rate your general health?

○ Excellent ○ Good ○ Fair ○ Poor

List current medications & the conditions they are treating?

List any major accidents or surgeries (including dates)

Please tell us about any allergies or hypersensitivities

Reason for initial visit

Please mark any of the following conditions you currently have.

HEAD / NECK:

- ○ Headaches / migraines
- ○ Ringing in ears
- ○ Vision problems
- ○ Vertigo / dizziness
- ○ Hearing loss
- ○ Vision loss

RESPIRATORY

- ○ Asthma
- ○ Chronic cough
- ○ Bronchitis
- ○ Emphysema
- ○ Frequent colds
- ○ Shortness of breath
- ○ Sinusitis
- ○ Smoker
- ○ Family history of respiratory difficulties

REPRODUCTIVE

- ○ Pregnant due date:
- ○ Gynecological problems
- ○ Given birth

NERVOUS SYSTEM

- ○ Sensory loss / change
- ○ Sciatica
- ○ Seizures
- ○ Numbness / tingling
- ○ Epilepsy
- ○ Multiple sclerosis

MUSCULOSKELETAL SYSTEM

- ○ Arthritis
- ○ Osteoporosis
- ○ Bursitis
- ○ Family history of arthritis
- ○ Jaw pain (TMJ)
- ○ Tendonitis
- ○ Pins / plates / wires / artificial joint

SKIN & INFECTIONS

- ○ Hepatitis
- ○ Herpes
- ○ Lyme disease
- ○ HIV / AIDS
- ○ Tuberculosis
- ○ Infectious skin conditions

CARDIOVASCULAR

- ○ High blood pressure
- ○ Heart attack
- ○ Heart disease
- ○ Phlebitis / varicose veins
- ○ Hemophilia
- ○ Stroke
- ○ Low blood pressure
- ○ Poor circulation
- ○ Pacemaker
- ○ Chronic congestive heart failure
- ○ Family history of cardiovascular problems

OTHER

- ○ Cancer
- ○ Unexplained weight loss
- ○ Fibromyalgia
- ○ Depression
- ○ Psychiatric disorder
- ○ Diabetes
- ○ Digestive conditions
- ○ Chronic fatigue syndrome
- ○ Anxiety
- ○ Other Conditions

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It is my choice to receive massage therapy. I am aware of the benefits and risks of massage and give my consent for massage. I understand that there is no implied or stated guarantee of success of effectiveness of individual techniques or series of appointments. I acknowledge that massage therapy is not a substitute for medical care, medical examination or diagnosis. I have stated all medical conditions that I am aware of and will inform my practitioner of any changes in my health status.

I understand that my personal health information will be collected. I understand that all information that I provide will be kept confidential unless required by law.

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Client Printed Name	Clients Signature	Date
.....	.....	.....
Therapist Name:	Therapist Signature	Date

MASSAGE INFORMATION

Have you had a professional massage before? (If yes, state the date of last treatment)

○ Yes ○ No .....

Are there any areas (feet, face, abdomen, etc.) you do not want massaged?

○ Yes ○ No If yes, please identify .....

Do you have any allergies to oils, lotions, or ointments?

○ Yes ○ No If yes, please identify .....

Is there a particular area of the body where you are experiencing tension, stiffness, pain or discomfort?

○ Yes ○ No If yes, please identify .....

Do you sit for long hours at a workstation, computer, or driving?

○ Yes ○ No If yes, please describe .....

Do you have any particular goals in mind for this massage session?

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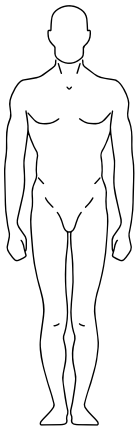
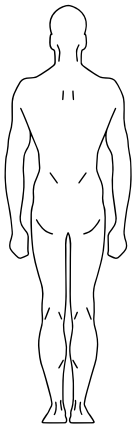
Circle any specific areas you would like the massage therapist to concentrate on during the session:

Front:



Right side:

Back:



Left side:

I acknowledge that the massage I receive is for relaxation and relief of muscular tension. If I feel any discomfort, I will inform the therapist immediately so that they can adjust the pressure and strokes to my comfort level.

I understand that massage is not a substitute for medical examination or treatment, and I should consult a doctor for any physical or mental health issues. I confirm that I have disclosed all known medical conditions and will update the therapist on any changes. I acknowledge that the therapist is not liable if I fail to do so.

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Client Printed Name Clients Signature Date