Massage Therapy Intake Form

Pickering Chiropractic

Health Centre

Pickering Chiropractic Health Centre
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Patient Information

Today's Date: (dd/mm/yyyy) . . . . . .

Full Name: . . . . . Birth Date: (dd/mm/yyyy) . . . . . .
Address: . . . . . City: . . . . . Province: . . . . . Postal Code: . . . . . .
Cell #: . . . . . Home #: . . . . . Work #: . . . . . .
Occupation: . . . . . E-mail: . . . . . .
Emergency Contact: . . . . . Relationship: . . . . . Phone #: . . . . . .

Medical Information

Medical Doctor's Name: . . . . . Clinic: . . . . . .
Date of last MD visit: . . . . . Reason: . . . . . .
What therapies have you previously received? ☐ Chiropractic ☐ Massage ☐ Acupuncture ☐ Physiotherapy

* The information request 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 confidentially unless allowed by law. Your written permission will be required to release any information.

How Did You Hear About Us?

☐ Referred by Friend/Family ☐ Referred by Medical Doctor ☐ Internet/Website ☐ Walk In ☐ Other: . . . . . .
*Whom may we thank for this referral? . . . . . .

Health History

Primary Complaint: . . . . . When did this begin? . . . . . .
Have you had this before? ☐ Yes ☐ No Is it getting better: ☐ Better ☐ Worse ☐ Not Changing
Please include the location and if there is any joint discomfort: . . . . . .
Please list any medication that you are currently taking and why: . . . . . .
. . . . . .
Currently receiving treatment by another health care professional? ☐ Yes ☐ No Reason? . . . . . .
Have you had major surgery: ☐ Yes ☐ No Nature/When? . . . . . .
List any other medical conditions? (e.g. digestive conditions, haemophilia, osteoporosis, mental illness) . . . . . .
. . . . . .
Do you have any internal pins, wires, artificial joints or special equipment? ☐ Yes ☐ No What/Where? . . . . . .

Please indicate conditions you are experiencing or have experienced:

Cardiovascular: ☐ High blood pressure ☐ Low blood pressure ☐ Chronic congestive heart failure ☐ Heart attack ☐ Phlebitis/ varicose veins ☐ Stroke/CVA ☐ Pacemaker or similar device Is there a family history of any of the above? ☐ Yes ☐ No

Respiratory: ☐ Chronic cough ☐ Shortness of breath ☐ Bronchitis ☐ Asthma ☐ Emphysema Is there family history? ☐ Yes ☐ No

Infections: ☐ Hepatitis ☐ Skin conditions ☐ TB ☐ HIV ☐ Herpes

Head/ Neck: ☐ History of headaches ☐ History of migraines ☐ Vision problems ☐ Vision loss ☐ Ear problems ☐ Hearing loss

Other Conditions: Loss of sensation ☐ Yes ☐ No Where? . . . . . Diabetes ☐ Yes ☐ No Onset: . . . . . .

Allergies/ hypersensitivity ☐ Yes ☐ No List: . . . . . Type of reaction: . . . . . .

Epilepsy ☐ Yes ☐ No Cancer ☐ Yes ☐ No Where? . . . . . Skin conditions ☐ Yes ☐ No Describe: . . . . . .

Arthritis ☐ Yes ☐ No What type? . . . . . Is there a family history of arthritis? ☐ Yes ☐ No

Rate your overall health? 0 1 2 3 4 5 6 7 8 9 10

For Women Patients Only

Are you pregnant? ☐ Yes ☐ No Due date? . . . . . .

List any gynaecological conditions: . . . . . .

Patient Informed Consent, Waiver and Release for Massage Therapy

I consent to the treatment and have provided the above information to the best of my knowledge and is accurate and up to date. Massage therapy is not a substitute for medical examination and diagnosis. It is recommended that I see a physician for any physical ailment that I may have. I understand that the massage therapist does not diagnose illnesses, disease or mental disorder. I confirm that I have stated all of my known medical conditions and understand that there shall be no liability on the part of the massage therapist, should I fail to do so. I will inform the therapist of any changes in my status.

Massage is a contraindication under certain medical conditions. I understand that the massage therapist reserves the right to refuse massage therapy on anyone whom he/she deems to have a condition that is a contraindication to massage.

I hereby assume full responsibility for receipt of massage therapy and release and discharge the massage therapist from any and all claims, liabilities, damages, actions or causes of action arising from the therapy received hereunder, including, without limitation, any damages arising from acts of active or passive negligence on the part of the therapist.

I hereby assume all responsibility to communicate any discomfort or pain during any point in the treatment, releasing any and all liability or responsibility of the Massage Therapist. The Massage Therapist may contact me and leave messages regarding appointments at any of the contact information I have provided.

Please note:

Payment is due at the time of treatment. Your appointment time has been reserved for you. As a courtesy to your therapist and fellow patients, please provide me with 24 hours' notice of cancellation, or a cancellation fee will be charged. Missed appointments will be billed at the full rate, unless 24 hours' notice is provided.

Please be aware that insurance companies do not reimburse for missed or cancelled appointments.

Payment for all treatment, whether private or insured, is ultimately the responsibility of the patient. I understand that I am ultimately responsible for the full cost of my appointments, including any event where my insurance company should deny their payment portion to the Registered Massage Therapist.

Date: _____, 20___

_____ Patient Signature

_____ Witness Signature

_____ Patient Name (Please Print)

_____ Witness Name (Please Print)

OFFICE USE ONLY: Date of initial health history: _____ Update 1: _____ Update 2: _____

Update 3: _____ Update 4: _____ Update 5: _____ Update 6: _____