Ellerslie Chiropractic & Wellness Centre
Massage Therapy Health History & Intake Form

To ensure the best professional care and therapeutic treatment, please take a few minutes to complete the following. The information that is provided is confidential and important, therefore should anything change, please notify your therapist. Your time and cooperation in completing this form is appreciated.

Today's Date: ____________________

Last Name: ____________________ First Name: ____________________

Address: ____________________ City/Province: ____________________

Postal Code: ____________________ Home Phone: ____________________

Business Phone: ____________________ Cell Phone: ____________________

Email Address (For Appointment Reminders): ____________________

Date of Birth: ____________________ Employer/School: ____________________

Occupation: ____________________

Physicians Name/Clinic: ____________________ Physician Ph #: ____________________

Emergency Contact Name: ____________________ Emergency Contact #: ____________________

Have you received a professional massage before? (Yes/No); If yes how long ago: ____________________

How did you hear about our clinic/Referred By? ____________________

<u>Main Reason for Massage? (Please circle all that apply):</u>

Relaxation/Wellbeing Stress/Tension Therapeutic Motor Vehicle/ Work Injury Pregnancy

If you are currently experiencing pain, please indicate specifically where: ____________________

When did the pain begin? ____________________

What actions worsen the pain? ____________________

What eases the pain? ____________________

To our valued massage clients: By signing below you recognize that scheduling an appointment involves a reservation time specifically for you, therefore a minimum of 24 hours' notice is required to reschedule or cancel an appointment. A missed appointment fee will be charged for sessions missed without such advanced notification. In addition please understand that most insurance companies will not reimburse for missed appointments.

Date: ____________________ Signature: ____________________

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For each of the conditions listed below, place a check in the *"Past"* column if you have had the condition in the past. If you presently have a condition listed below, place a check in the *"Present"* column.

Past	Present		Past	Present		Past	Present	
☐	☐	Headaches	☐	☐	High Blood Pressure	☐	☐	Diabetes
☐	☐	Neck Pain	☐	☐	Heart Attack	☐	☐	Excessive Thirst
☐	☐	Upper Back Pain	☐	☐	Chest Pains	☐	☐	Frequent Urination
☐	☐	Mid Back Pain	☐	☐	Stroke	☐	☐	Allergies
☐	☐	Low Back Pain	☐	☐	Angina	☐	☐	Depression
☐	☐	Shoulder Pain	☐	☐	Kidney Stones	☐	☐	Systemic Lupus
☐	☐	Upper Arm Pain	☐	☐	Kidney Disorders	☐	☐	Epilepsy
☐	☐	Elbow Pain	☐	☐	Bladder Infection	☐	☐	Dramatis/Eczema
☐	☐	Wrist Pain	☐	☐	Painful Urination	☐	☐	Warts
☐	☐	Hand Pain	☐	☐	Loss of Bladder Control	☐	☐	HIV/Aids
☐	☐	Hip/Upper Leg Pain	☐	☐	Prostate Problems	☐	☐	Hepatitis
☐	☐	Knee/Lower Leg Pain	☐	☐	Abnormal Weight Gain/Loss			
☐	☐	Ankle/Foot Pain	☐	☐	Loss of Appetite			
☐	☐	Jaw Pain	☐	☐	Abdominal Pain			<u>FEMALES ONLY</u>
☐	☐	Joint Stiffness	☐	☐	Ulcer	☐	☐	Pregnancy
☐	☐	Dizziness	☐	☐	Tumor	☐	☐	Birth Control
☐	☐	Visual Disturbances	☐	☐	Asthma	☐	☐	Hormone Replacement
☐	☐	Fibromyalgia	☐	☐	Chronic Sinusitis			

Please describe any of your above conditions (including when/where): ______________________________
____
____
____

Have you ever had any injuries such as broken bones, torn ligaments, surgeries etc.? When?________________
____

What medications are you currently taking (over the counter/prescribed/herbal) and for what condition: ________
____

What types of physical activities do you participate in during your spare time, and how often? ______________
____

I have completed this health form to the best of my knowledge. I understand that massage therapy services are a therapeutic health aid and are non-sexual. I understand that massage therapy does not diagnose illness or disease and that the massage therapist does not prescribe medical treatment or pharmaceuticals, nor are spinal manipulations part of massage therapy. If there are any changes to my health history throughout the course of my massage therapy treatments I will advise the massage therapist.

I understand that massage therapy is not a substitute for medical examination or medical care, and that it is recommended that I am concurrently working with my primary caregiver for any condition I may have.

Client Signature:________________________________ Date:__________________________

Parent or Guardian Signature (if client under 18 years): ______________________________