BACK & BODY HEALTH
CALGARY MASSAGE CLINIC
MASSAGE THERAPY INTAKE FORM

PERSONAL INFORMATION			
Name:			Today's Date (mm/dd/yyyy):
Date of birth (mm/dd/yyyy)		Age:	Gender: ❑ Female ❑ Male
Address			
City:	Province:		Postal Code:
Home telephone:		Business telephone:	
Your occupation:		Employer:	
E-mail address:			
Permission for correspondence through		❑ Mail ❑ Occasion cards ❑ E-mail ❑ Other:	

In case of emergency, whom should we notify?	
Relation to you:	Contact number:

Family Doctor:	Contact Number:
Permission to consult with family doctor	❑Yes ❑ No

How did you hear about our office	❑ Health Care Prof. ❑ Friend ❑ Sign ❑ Internet ❑ Other: _____
If you checked friend who can we thank:	

REASON FOR APPOINTMENT

What is your chief complaint?

Describe the onset

Provide the primary symptoms. Rate the symptoms mild, moderate or severe

Using an "X", please rate you pain on the line below

No Pain _____Very Painful

1 5 10

Is this a car accident case	❑ Yes ❑ No	Have you recently been in an accident	❑ Yes ❑ No
***** If YES, please fill out Notice of loss & Proof of Claim (form AB-1) and MVA form *****			

Have you seen any other physician or health care professional for this complaint ❑ Yes ❑ No	
If YES, Doctors Name:	Date of last treatment:
Diagnosis:	What type of treatment did you receive:

Were you medically cleared for treatment? ❑ Yes ❑ No
List current medications, including aspirin, ibuprofen, antihistamines, birth control etc. and their purpose:
Do you suffer from headaches: ❑ Yes ❑ No If yes how often?
How long do they last?

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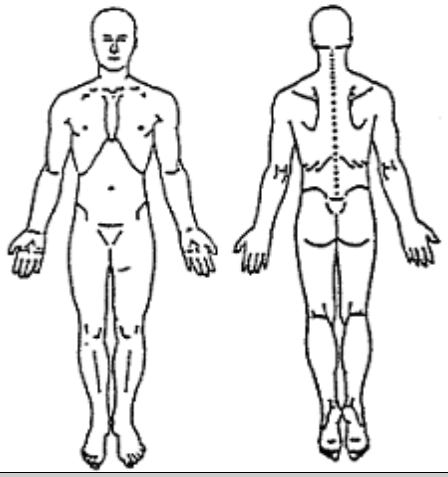
Mark the area(s) of pain or unusual feeling using the appropriate symbols.
▪ Circles area of PAIN
▪ "X" over the areas of JOINT AND MUSCLE STIFFNESS
▪ Draw squiggly lines along the areas of NUMBNESS, TINGLING OR ALTERED SENSATION
▪ Additional comments:



HEALTH HISTORY

Please check the appropriate box of any of the following symptoms that you now have or have had previously.

If the symptom is not applicable to you, please leave blank.

C = Constant F = Frequent O = Occasional

C F O	C F O	C F O
MUSCLE & JOINT ❑ ❑ ❑ Tendonitis ❑ ❑ ❑ Bursitis ❑ ❑ ❑ Broken / Fractured bones ❑ ❑ ❑ Sprains / Strains ❑ ❑ ❑ Low back / hip / leg pain ❑ ❑ ❑ Neck / shoulder / arm pain ❑ ❑ ❑ Spasms / cramps ❑ ❑ ❑ Jaw pain / TMJ Do you have: ❑ Yes ❑ No Bone or Joint disease ❑ Yes ❑ No Arthritis ❑ Yes ❑ No Flat feet / High arches SKIN ❑ ❑ ❑ Dryness ❑ ❑ ❑ Skin rash ❑ ❑ ❑ Athletes foot ❑ ❑ ❑ Warts ❑ Yes ❑ No Bruise easily ❑ Yes ❑ No Hives or allergy ❑ Yes ❑ No Acne / open wounds / sores Location:	RESPIRATORY ❑ Yes ❑ No Chronic cough ❑ Yes ❑ No Asthma ❑ Yes ❑ No Allergies Type: NERVOUS SYSTEM ❑ ❑ ❑ Numbness / Tingling Location: ❑ ❑ ❑ Herpes / Shingles Location: ❑ ❑ ❑ Fatigue ❑ Yes ❑ No Chronic pain CARDIO-VASCULAR ❑ Yes ❑ No Heart condition ❑ Yes ❑ No Varicose veins ❑ Yes ❑ No Blood clots ❑ Yes ❑ No High blood pressure ❑ Yes ❑ No Low blood pressure ❑ Yes ❑ No Lymphedema ❑ Yes ❑ No Hemophilia ❑ Yes ❑ No Stroke -When_____ ❑ Yes ❑ No Arteriosclerosis	GENITO-URINARY ❑ ❑ ❑ Kidney infection ❑ Yes ❑ No Pregnant: #Months __ GASTRO-INTESTINAL ❑ ❑ ❑ Constipation ❑ Yes ❑ No Digestive problems OTHER – Do you have/take ❑ Yes ❑ No Poor nutrition ❑ Yes ❑ No Drugs/medication Type: ❑ Yes ❑ No Alcohol: # per week __ ❑ Yes ❑ No Caffeine cups per day__ ❑ Yes ❑ No Epilepsy ❑ Yes ❑ No Cancer / tumors Type: ❑ Yes ❑ No Diabetes Type: ❑ Yes ❑ No Mental Health Type: ❑ Yes ❑ No Infectious disease Type: ❑ Yes ❑ No Concussion Symptoms

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Surgery / Injury: Accidents: Other Medical Conditions:

WAIVER:
I have stated all medical conditions that I am aware of and will update the massage practitioner of any changes in health status. I agree to immediately inform the therapist if I experience any pain of discomfort during my massage so that the pressure and / or strokes may be adjusted to my level of comfort. I also agree to request the massage therapist to stop treatment if I feel like my well-being is being compromised in any way. I assume all risks and responsibilities for myself and release the Massage Therapist and Back & Body Health from responsibility from any injury or liability that may occur during a treatment session.

Signature	Date