Bolton Physiotherapy Clinic

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Massage Intake Form

Today's Date

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 or required by law. Your written permission will be required to release any information.

PATIENT INFORMATION

First Name:

DOB:

Last Name:

Phone:

Street Address:

Province:

City/ Town:

Post Code:

Email:

Have you received massage therapy before? ☐ Yes ☐ No

Did a healthcare practitioner refer you to massage? ☐ Yes ☐ No

If yes, please provide their name/address.

HEALTH HISTORY

Please indicate conditions you are, or have experienced.

Cardiovascular

- ☐ High blood pressure
- ☐ Low Blood Pressure
- ☐ Chronic Congestive Heart Failure
- ☐ Heart Attack
- ☐ Phlebitis/Varicose Veins
- ☐ Stroke/CVA
- ☐ Pacemaker or Similar
- ☐ Heart Disease

Is there a family history of any of the above?

☐ Yes ☐ No

Respiratory

- ☐ Chronic Cough
- ☐ Shortness of Breath
- ☐ Bronchitis
- ☐ Asthma
- ☐ Emphysema

Is there a family history of any of the above?

☐ 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

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Other Conditions

- ☐ Loss of sensation? Where:
- ☐ Diabetes? Onset:
- ☐ Allergies? What:
- ☐ Type of reaction:
- ☐ Epilepsy
- ☐ Cancer? Where:
- ☐ Skin Condition? What?
- ☐ Arthritis

Is there a family history of arthritis? ☐ Yes ☐ No

- ☐ Current Medications:

Condition it Treats:

Are you currently receiving treatment from another healthcare provider? ☐ Yes ☐ No

If Yes, for what?

- ☐ Surgery? Date/Nature:
- ☐ Injury? Date/Nature:

Women

- ☐ Pregnant? Due:
- ☐ Gynaecological Conditions? What:

Overall, how is your general health?

Primary Care Physician:

Address:

Do you have any other medical conditions? (Digestive, haemophilia, osteoporosis, mental illness?) ☐ Yes ☐ No

If Yes, what?

Do you have any internal pins, wires, artificial joints or special equipment? ☐ Yes ☐ No

If Yes, what/where?

What is the reason you are seeking massage therapy?

INSURANCE INFORMATION

Name of Insurance Company

Policy/Group No:

ID/Certificate:

Insurer Name:

NOTES

HEALTH HISTORY TIMELINE

Initial

Update 1

Update 2

Update 3

Update 4

Signature:

Date: