THE MASSAGE CLINIC
HEALTH CENTRES

Physiotherapy/Athletic Therapy

Intake Form

Contact Information

Please Circle: Mr. Mrs. Miss Ms. Dr. Sir

Name:_____ Address:_____

City:_____ Province:_____ Postal Code:_____

Phone # Home:_____ Work:_____ Cell:_____

Email:_____ Date of Birth: Day_____ Month_____ Year_____

Age:_____ Gender (please circle) Male Female

Occupation:_____ Hrs/week:_____ Work Posture:_____

Emergency Contact Name:_____Phone #:_____Relationship:_____

Who referred you to our clinic? Or how did you hear of us?_____

Medical Information

Height:_____ Weight:_____ # of Children:_____

Have you had orthotics previously? (Please circle) Yes / No

Medical Doctor:_____ Address:_____

Phone:_____

Have you previously been seen by a physiotherapist? (Please circle) Yes / No

If yes, for what condition(s):_____

Please check the appropriate response according to your condition(s):

- ☐ My current injury(s)/condition(s) has been previously treated by a health care professional
- ☐ My current injury(s)/condition(s) is a new problem I am experiencing

Have you seen (in the past) or are you currently seeing any of the following health care professionals? (Please check)

- ☐ Massage Therapist
- ☐ Chiropractor
- ☐ Osteopathic Manual Practitioner
- ☐ Athletic Therapist
- ☐ Naturopathic Doctor and/or Registered Acupuncturist
- ☐ Specialists (ex. Orthopedic specialist, etc.)

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Conditions & Symptoms

Please circle any **current** conditions or symptoms.

Please check beside **past** conditions or symptoms.

General Symptoms
Loss of consciousness
Blackouts
Headaches/Migraines
Fever
Sweats
Fainting
Dizziness
Clumsiness
Convulsions/Tremors
Loss of sleep
Loss of weight
Depression
Fatigue
Nervousness
Numbness/Pain or Tingling

Muscle & Joint
Arthritis
Weakness/Loss of strength
Swollen joints
Back pain
Shoulder pain
Arm/forearm pain
Elbow pain
Wrist pain
Hand pain
Knee/leg pain
Painful tailbone
Foot trouble
Stiff neck
Sciatica
Scoliosis

Skin
Sensitive skin/loss of sensation
Rashes/eruptions/itching
Acne
Cold sores
Infectious skin condition
Bruise easily
Hives
Eczema/psoriasis
Boils

Gastrointestinal
Blood in stool
Vomit
Colitis/Crohn's
Constipation
Diarrhea
Difficult digestion/indigestion
Poor appetite/excessive hunger
Belching or Gas
Vomit (blood?)
Food allergies:
Gall bladder troubles
Heart burn
Jaundice/Liver trouble
Nausea
Pain over stomach
Intestinal worms
Ulcers

Eyes/Ear/Nose/Throat
Blurred vision
Double vision
Eye pain
Deafness
Ear issues:
Frequent colds
Enlarged glands
Enlarged thyroid
Nose bleeds
Sinus infection
Difficulty swallowing
Speech problems

Respiratory
Asthma
Anaphylaxis
Chest pain
Chronic cough
Bronchitis
Spitting up blood
Spitting up phlegm
Wheezing
Shortness of breath
Emphysema
Infectious respiratory condition
Family history

Cardiovascular
Pain over heart
Poor circulation
Swelling of extremities
High/Low blood pressure
Hardening of arteries
Varicose veins
Heart or blood disease:
Presence of pacemaker
Heart attack/stroke
Family history

Other Conditions
Epilepsy
Herpes
Hepatitis
Plantar warts
TB
HIV, AIDs
Diabetes: please circle
Type I Type II
Gout
Fibromyalgia
Multiple Sclerosis
Parkinson's
Hemophilia
Osteoporosis
Other:

Women Only
Breast tenderness/swollen breasts
Cramps or backache
Excessive flow
Irregular cycles
Menopausal (hot flashes, mood swings)
Painful menstruation
Pregnant – Due Date:
# of children:
Hysterectomy

Genitourinary
Trouble urinating
Blood in urine
Kidney infection
Bed wetting
Prostate trouble

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Conditions & Symptoms Continued…

Please indicate if you have/had/been any of the following:

Falls/fractures/dislocations	Date:_____
Pins/plates/rods	Date:_____
Surgery	Date:_____
Accidents	Date:_____
Hospitalized	Date:_____
Knocked unconscious	Date:_____

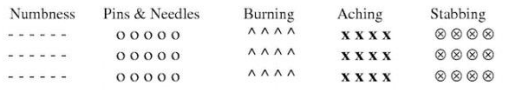
How is your general health?_____

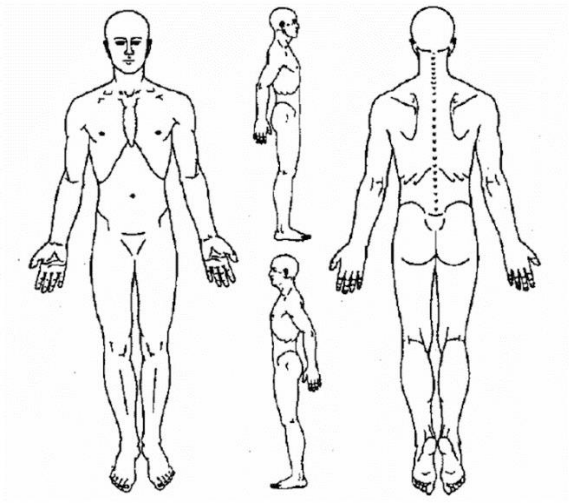
Are you currently a smoker?	Yes	No
Have you ever smoked in the past?	Yes	No
Have you ever been diagnosed with cancer?	Yes	No
Do you take medication on a regular basis?	Yes	No

If so, what? (blood thinner, blood pressure, etc.)_____

Area of Major Complaint:_____

In the diagram provided below, please mark the areas on your body which you feel represent the pain(s) or sensation(s) you are experiencing. Please include *all* areas. Use the symbols provided below.





Please indicate your level of pain along the line below with an 'x'. 0 represents no pain and 10 represents the worse pain you have ever felt.