Massage Therapy – New Patient Information

Name: _____ Date: _____

Address: _____ Postal Code: _____
Telephone: (h) _____(c) _____(w) _____
Email: _____

Date of Birth: _____ Occupation: _____

Activities: _____
_____
Allergies: _____
Medications: _____

How did you hear about our office (please circle one):
Internet Sign Location Referral: _____

Physiotherapist:_____ Chiropractor: _____
What is your presenting complaint? _____
_____

Do you know what caused this problem? _____
_____

When do you experience the pain? (ie: Sleep? Morning? After Activity?) _____
_____
_____

How long does it last? _____

Describe the pain (sharp, dull, numbness, tingling, aching, stabbing etc): _____
_____
_____

What relieves the pain? _____

Have you had any other injuries, surgeries or car accidents? If so, please describe and give date(s): _____
_____
_____

History of cancer recently or in the past five years? Yes / No _____
Describe: _____
Are you HIV positive? Yes / No

WOMEN ONLY: ARE YOU PREGNANT? Yes / No Due Date: _____

PLEASE CHECK OFF ANY OF THE FOLLOWING THAT APPLY TO YOU:

☐	Rheumatoid Arthritis	☐	Asthma
☐	Fatigue	☐	Heart Attack
☐	Abdominal Pain	☐	Stroke
☐	Swelling of Joint	☐	Skin Condition
☐	Diabetes	☐	Morning Stiffness
☐	Fractured Vertebrae	☐	Crunching / Grinding
☐	Spine Tender to Touch	☐	Multiple Joint Pain
☐	Respiratory / Urinary Infection	☐	Numbness / Tingling
☐	Bone Pain	☐	Dizziness
☐	Low Back Pain	☐	Headaches
☐	Varicose Veins	☐	Fainting
☐	Osteoporosis	☐	Pins, Plates or Prosthesis
☐	Brain Tumors	☐	Weakness of Arm, Leg, Hand, Foot

Please indicate any conditions not mentioned above: _____

_____

_____

_____

I declare the information on this form to be true and correct in all respects. While rare, some patients may experience short term aggravation of symptoms, muscle and ligament sprains or strains, bruising or rib fractures as a result of massage therapy. I acknowledge that I have discussed, or have had the opportunity to discuss with my massage therapist the nature and purpose of massage therapy in general and my treatment as well as the contents of this consent. I consent to the massage therapy treatment offered or recommended to me by my massage therapist. I intend this consent to all my present and future massages.

Client Name (please print): _____

Client Signature: _____ Date: _____