Massage Therapy Intake and History Form · Oakridge Chiropractic Centre

Name _____ Date of Birth _____

Address _____ ☐ Male ☐ Female

_____ Referred here by _____

_____ Postal Code _____ Medical Doctor _____

Home Phone _____ Your Occupation _____

Cell Phone _____ Work Phone _____

Email _____ Preferred contact for reminders ☐ H ☐ C ☐ W ☐ Email

Clinical Data

Reason for seeking massage therapy today _____

_____

Injury/pain started when? _____

What actions aggravate pain? _____

What actions ease pain? _____

Does pain radiate? (pain goes beyond area of injury) ☐ No ☐ Yes If yes, where? _____

Past injuries/surgeries (include dates) _____

_____

Any stiffness/pain as a result of past injuries? ☐ No ☐ Yes If yes, where? _____

Female patients: Are you pregnant? ☐ No ☐ Yes If yes, how many months? _____

Medications and Supplements

Name of Drug/Supplement	Dosage per day	Reason for taking

Check if any apply to you:

☐ Cancer ☐ Epilepsy ☐ Heart disease
☐ High/low blood pressure ☐ Diabetes ☐ Varicose veins
☐ Stroke ☐ Herniated disk ☐ Other (specify) _____
☐ Pins/rods/artificial limbs ☐ Pacemaker _____

Check any which you experience once or twice per week:

☐ Headache ☐ Constipation ☐ Faintness/Dizziness
☐ Loose bowel movements ☐ Tightness of jaw ☐ Soreness in muscles
☐ Weakness in parts of body ☐ Pains in heart/chest ☐ Insomnia
☐ Indigestion ☐ Nervousness ☐ Frequent urination
☐ Poor appetite ☐ Fatigue ☐ Lower back pain
☐ Cold hands and feet ☐ Grinding of teeth ☐ Heavy feeling in limbs
☐ Smoking (# per day _____) ☐ Allergies _____ ☐ Other _____

Informed Consent for Massage Therapy · Oakridge Chiropractic Centre

Please read and check beside each of the following statements to indicate your informed consent

☐ I understand that massage is given here for therapeutic purposes such as: relief from muscular tension, spasm or pain; increasing circulation; stress reduction.

☐ I understand that the massage therapist does not diagnose illness, disease, or any other physical or mental disorder, or prescribe medical treatment or pharmaceuticals, or perform spinal manipulations. I understand that I should see a physician and/or chiropractor as needed, since massage is not a substitute for medical and/or chiropractic examination or diagnoses.

☐ I understand that time spent pre-massage discussing health issues and concerns with the therapist is included as part of the time booked for my treatment.

☐ I have stated all my known medical conditions and medications. I understand that it is entirely my responsibility to keep the massage therapist updated on my physical health and medication changes.

☐ I understand that payment is expected at the time of my appointment, and that direct billing to my private insurance/benefits provider is not done at this clinic.

☐ **I understand that if I miss my appointment, or cancel with less than 24-hours notice, I may be subject to a cancellation charge equivalent to the appointment fee.**

☐ I understand that if I am late for my appointment, the length of my massage time may be shortened so that the massage therapist, and patients with appointments booked after me, are not inconvenienced. I am still responsible for payment for the full amount of time that was initially booked for my appointment.

☐ In order to get the most benefit from my massage, and to allow the massage therapist to work uninterrupted, I agree to turn off any cell phones, pagers, etc. before the massage begins.

☐ I understand that any inappropriate or abusive behaviours or comments directed at the massage therapists or the staff will not be tolerated, and I will be asked to leave immediately.

By signing below, I agree that I have read and understood the informed consent, and have completed this intake form as completely and accurately as possible, for the benefit of both myself and the therapist.

Patient Name _____ Witness Name _____
(please print) (please print)

Patient Signature _____ Witness Signature _____

Date _____

Oakridge Chiropractic