Ware Therapeutic Massage & Acupuncture Windermere LTD.

Massage Intake Form

PATIENT INFORMATION

Name_____ Phone(day)_____(evening)_____

Address_____City_____Prov_____postal_____

DOB:_____ Occupation_____

Employer_____

Email_____ Primary Physician_____

Emergency contact/phone _____/_____ Relationship_____

How did you hear about us? _____

Medical Information

Are you taking any medications? ☐ yes ☐ No If yes, please list name and use:

_____

Are you currently pregnant? ☐ yes ☐ No If yes, how far along? _____

Is this pregnancy considered high risk? _____

Is this visit due to a Car accident or WCB claim? ☐ yes ☐ No Which? _____

Do you suffer from chronic pain? ☐ yes ☐ No If yes, please explain _____

What makes it better? _____ What makes it worse? _____

Have you had any major injuries/ surgeries? ☐ yes ☐ No If yes, please list,

when :_____

Please indicate any of the following that apply to you currently or have had in the past .

☐ Headaches/Migraines	☐ Joint Replacements(s)	☐ Arthritis	☐ Diabetes
☐ High Blood Pressure	☐ Low Blood Pressure	☐ Neuropathy	☐ Fibromyalgia
☐ Kidney Dysfunction	☐ Sprains or Strains	☐ Heart Attack	☐ Cancer
☐ Stroke	☐ Numbness	☐ Lower back pain	☐ neck/Shoulder pain
☐ Stiff or painful joints	☐ Leg pain	☐ Chest Pain	☐ Tingling

Explain any conditions you have marked above:

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Massage Information

Have you had a professional massage before? ☐ yes ☐ No

What type of massage are you seeking? ☐ Relaxation ☐ therapeutic/Deep Tissue

Other _____

What pressure do you prefer: ☐ Light ☐ Medium ☐ Deep

Do you have any allergies or sensitivities? ☐ yes ☐ No Please explain _____

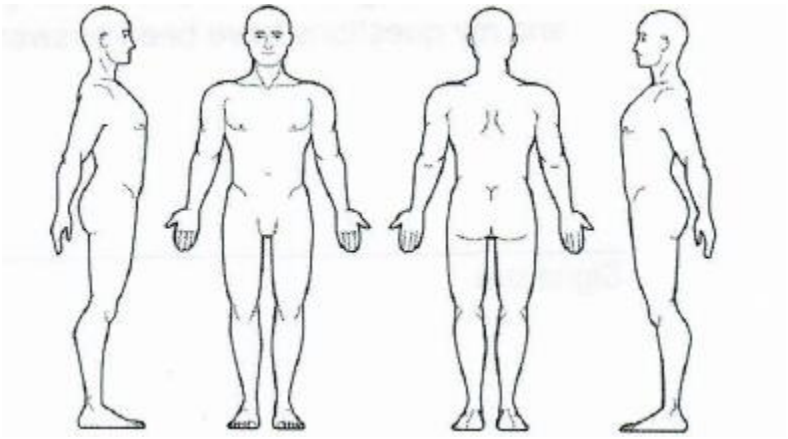
Are there any areas (feet, face, abdomen, etc.) you **do not want massaged**? ☐ yes ☐ No

Please explain_____

Extracurricular activities? _____

What are your goals for this treatment session? _____

Please Circle any Areas of discomfort



By signing below, you agree to the following.

I have completed this form to the best of my ability and knowledge and agree to inform my therapist if any of the above information changes at any time. I give my permission to receive massage therapy. I understand that therapeutic massage is not a substitute for traditional medical treatment or medications. I understand that the massage therapist dose not diagnose illnesses or injuries, or prescribe medications. I have clearance from my physician to receive massage therapy. I understand the risks associated with massage therapy include, but are not limited to superficial bruising or short-term muscle soreness or exacerbation of undiscovered injury. I therefore release the company and the individual massage therapist from all liability concerning these injuries that may occur during the massage session.

Client Signature _____ Date_____