

## Massage Therapy Medical History Intake Form

PLEASE COMPLETE THIS FORM IN FULL. ALL INFORMATION IS STRICTLY CONFIDENTIAL.

Date: \_\_\_\_\_ Email: \_\_\_\_\_

Name: \_\_\_\_\_ Age: \_\_\_\_ Date of Birth: \_\_\_\_\_  
Last First

Home Address: \_\_\_\_\_

Province: \_\_\_\_\_ Postal Code: \_\_\_\_\_ Occupation: \_\_\_\_\_

Home Phone #: \_\_\_\_\_ Business/Cell Phone #: \_\_\_\_\_

General Practitioner: \_\_\_\_\_ Address: \_\_\_\_\_ Phone #: \_\_\_\_\_

Date of Last Medical Exam: \_\_\_\_\_ Referred By: \_\_\_\_\_

List of Past Surgeries, including Dates:

List of Past Injuries/Accidents, including dates:

---

---

---

---

---

---

---

---

Please list ALL medications you are currently taking, OR have taken in the last six months:

Medication/Reason for Taking

Medication/Reason for Taking

Are you currently undergoing any forms of treatment? Please detail.

---

---

**Do you exercise regularly (3 Times Per Week):**                      Yes    No

**If you experience any of the following symptoms during, or shortly after, physical activity please circle:**

Extreme Muscle                      Difficulty Breathing                      Headaches                      Chest Pain  
Soreness

Extreme                      Abdominal Discomfort                      Dizziness                      Other:  
Weakness/Fatigue

**Is there anything else you think is important pertaining to your complaint?**

---

---

---

**Are you pregnant?** \_\_\_\_\_

**If Yes, what trimester?** \_\_\_\_\_

**Number of Children:** \_\_\_\_\_

**Complications with Pregnancy?** \_\_\_\_\_

**Complications with Labour & Delivery?** \_\_\_\_\_

**Do you have any surgical implants, such as artificial joints, pins, needles, metal plates, pacemaker, other? If yes, where?**

---

---

**How would you describe your present state of health?** \_\_\_\_\_

---

**What is your main complaint?** \_\_\_\_\_

---

---

**PLEASE CHECK ANY PAST, OR CURRENT, HEALTH PROBLEMS**

<b>Digestive System:</b>	<b>Gynecological/Urological System:</b>	<b>Cardiovascular System:</b>
<input type="checkbox"/> Heart Burn <input type="checkbox"/> GERD <input type="checkbox"/> Ulcers (Location: _____) <input type="checkbox"/> Gas/Bloating <input type="checkbox"/> Feeling of Heaviness <input type="checkbox"/> Nausea <input type="checkbox"/> Loss of Appetite <input type="checkbox"/> Increased Appetite <input type="checkbox"/> Dysphagia (Difficulty Swallowing) <input type="checkbox"/> Food Allergies <input type="checkbox"/> Hemorrhoids <input type="checkbox"/> Cirrhosis <input type="checkbox"/> Hepatitis (Type: _____) <input type="checkbox"/> Gallstones <input type="checkbox"/> Diarrhea <input type="checkbox"/> Constipation <input type="checkbox"/> IBS <input type="checkbox"/> Celiac Disease <input type="checkbox"/> Chron's Disease <input type="checkbox"/> Ulcerative Colitis	<b>Women:</b> <input type="checkbox"/> Dysmenorrhea <input type="checkbox"/> Irregular Menstruation <input type="checkbox"/> Fibroids/Uterine Cysts <input type="checkbox"/> Pelvic Inflammatory Disease <input type="checkbox"/> Endometriosis <input type="checkbox"/> IUD <input type="checkbox"/> Menopause <input type="checkbox"/> Loss of Pregnancy <input type="checkbox"/> Ovarian/Cervical Cancer <input type="checkbox"/> Herpes/STDs  <b>Men:</b> <input type="checkbox"/> Prostatitis <input type="checkbox"/> Sexual Dysfunction <input type="checkbox"/> Benign Prostatic Hypertrophy <input type="checkbox"/> Prostate Cancer <input type="checkbox"/> Epididymitis/Orchitis <input type="checkbox"/> Herpes/STDs	<input type="checkbox"/> Phlebitis <input type="checkbox"/> Varicose Veins <input type="checkbox"/> Chest Pain/Cramps <input type="checkbox"/> Angina <input type="checkbox"/> High Blood Pressure <input type="checkbox"/> Low Blood Pressure <input type="checkbox"/> High Cholesterol <input type="checkbox"/> Arrhythmia <input type="checkbox"/> Myocardial Infarction (Heart Attack) <input type="checkbox"/> Heart Palpitations <input type="checkbox"/> Numbness <input type="checkbox"/> Cold Hands/Feet <input type="checkbox"/> Aneurysm <input type="checkbox"/> CVA/Stroke <input type="checkbox"/> Atherosclerosis <input type="checkbox"/> Anemia <input type="checkbox"/> Hemophilia <input type="checkbox"/> Congestive Heart Failure
<b>Respiratory System:</b>	<b>Nervous System:</b>	<b>Musculoskeletal System:</b>
<input type="checkbox"/> Asthma <input type="checkbox"/> Bronchitis <input type="checkbox"/> Pneumonia <input type="checkbox"/> Emphysema <input type="checkbox"/> Allergies <input type="checkbox"/> Cold/Flu <input type="checkbox"/> Dyspnea (Shortness of Breath) <input type="checkbox"/> COPD <input type="checkbox"/> Pulmonary Embolism <input type="checkbox"/> Pulmonary Edema <input type="checkbox"/> Tuberculosis	<input type="checkbox"/> Epilepsy <input type="checkbox"/> Headaches <input type="checkbox"/> Migraines <input type="checkbox"/> Dizziness <input type="checkbox"/> Vertigo <input type="checkbox"/> Fainting <input type="checkbox"/> Balance Problems <input type="checkbox"/> Neuralgia <input type="checkbox"/> Paralysis <input type="checkbox"/> Multiple Sclerosis <input type="checkbox"/> Parkinson's <input type="checkbox"/> Neuritis	<input type="checkbox"/> Pain (Location: _____) <input type="checkbox"/> Bursitis <input type="checkbox"/> Tendonitis <input type="checkbox"/> Rheumatoid Arthritis <input type="checkbox"/> Osteoarthritis <input type="checkbox"/> Dislocation <input type="checkbox"/> Muscle/Joint Strain <input type="checkbox"/> Weakness/Loss of Strength <input type="checkbox"/> Clumsiness <input type="checkbox"/> Ankylosing Spondylitis <input type="checkbox"/> Gout

**PLEASE CHECK ANY PAST, OR CURRENT, HEALTH PROBLEMS**

<b>Immune/Lymphatic System:</b>	<b>Urinary System:</b>	<b>Ear/Nose/Throat:</b>
<input type="checkbox"/> Systemic Lupus Erythematosus <input type="checkbox"/> Reiter's Syndrome <input type="checkbox"/> Edema <input type="checkbox"/> HIV/AIDS <input type="checkbox"/> Lymphoma <input type="checkbox"/> Swollen Lymph Nodes (Location: _____)	<input type="checkbox"/> Urinary Tract Infection <input type="checkbox"/> Dysuria (Painful Urination) <input type="checkbox"/> Polyuria <input type="checkbox"/> Nocturia <input type="checkbox"/> Burning on Urination <input type="checkbox"/> Kidney Stones <input type="checkbox"/> Kidney Failure <input type="checkbox"/> Incontinence <input type="checkbox"/> Ptosis of Bladder <input type="checkbox"/> Polycystic Kidney Disease	<input type="checkbox"/> Rhinitis/Sinusitis <input type="checkbox"/> Polyps <input type="checkbox"/> Otitis/Ear Infections <input type="checkbox"/> Tonsillitis/Strep Throat <input type="checkbox"/> Tinnitus <input type="checkbox"/> Hearing Loss <input type="checkbox"/> Myopia (Near Sighted) <input type="checkbox"/> Hyperopia (Far Sighted) <input type="checkbox"/> Astigmatism <input type="checkbox"/> Conjunctivitis (Pink Eye) <input type="checkbox"/> Glaucoma <input type="checkbox"/> Fillings/Root Canals <input type="checkbox"/> Tooth Extractions <input type="checkbox"/> Orthodontic Work <input type="checkbox"/> Dental Implants <input type="checkbox"/> Tubes in Ears <input type="checkbox"/> Dental Appliances <input type="checkbox"/> Reconstructive Surgery
<b>Integumentary System:</b>	<b>Endocrine System:</b>	<b>Other:</b>
<input type="checkbox"/> Scleroderma <input type="checkbox"/> Acne <input type="checkbox"/> Herpes/Cold Sores <input type="checkbox"/> Dermatitis <input type="checkbox"/> Eczema <input type="checkbox"/> Psoriasis <input type="checkbox"/> Parasites (incl. Ring Worm)	<input type="checkbox"/> Pancreatic Disorder <input type="checkbox"/> Pituitary Disorder <input type="checkbox"/> Hyperthyroidism <input type="checkbox"/> Hypothyroidism <input type="checkbox"/> Pineal Gland Disorders <input type="checkbox"/> Menopause <input type="checkbox"/> Depression	<input type="checkbox"/> Osteoporosis <input type="checkbox"/> Cancer (Type: _____) <input type="checkbox"/> Undiagnosed Lump <input type="checkbox"/> Inguinal Hernia <input type="checkbox"/> Hiatal Hernia <input type="checkbox"/> Umbilical Hernia <input type="checkbox"/> Other: _____ _____

**I Certify the Information Provided in this Form is True and Accurately Reflects My Past, and Present, Health Status.**

\_\_\_\_\_

**Patient (or Guardian) Signature** **Date**

## Consent to Assessment and Treatment

I \_\_\_\_\_ consent to assessment, and treatment, for my present complaint. I understand I have been asked to wear loose fitting clothing for purposes of this assessment and/or treatment.

I further understand I may stop assessment and/or treatment at any time, and for any reason.

**Further, I have been informed, by Candace Kakowchyk, the treatment I will receive is Massage Therapy, which includes advanced Massage Therapy techniques.**

My therapist has provided me with all relevant information to the treatment and I understand the benefits, risks and side effects of this treatment plan. I have also been provided, and understand, alternative courses of treatment where applicable. All of my questions regarding all aspects of the assessment, treatment and treatment plan, have been addressed and answered.

---

Patient Signature

---

Date

## Cancellation Policy

By signing this form the patient agrees to give **48 business hours** notice when canceling appointments. The patient also agrees if **48 business hours** notice is not given they will be responsible for the full treatment fee.

Receipts issued for missed appointments will state **Missed Appointment**, and further appointments will not be scheduled until payment is received.

---

Patient Signature

---

Date

## Privacy Policy

I understand all information collected on this form is for the sole purpose and use of my therapist, and is collected in accordance with the Personal Health Information Protection Act (PHIPA, 2004) and the Personal Information Protection and Electronic Documents Act (PIPEDA, 2000). My name, address, email and phone number are collected in order for my therapist to contact me regarding any appointment changes, payment inquiries, or news and changes applicable to the clinic. They will not be solicited or sold to any outside source, and will remain on the clinic premises at all times. I understand this information may, however, be accessed by regulatory authorities as outlined in the Regulated Health Professionals Act (RHPA), the Registered Massage Therapists Association of Ontario (RMTAO), and/or the College of Massage Therapists of Ontario (CMTO).

I understand my therapist will not, under any condition, supply my insurer, doctor, or anyone else, with my confidential medical and treatment history without first receiving my express written consent. The same applies if my therapist requires permission to contact my doctor in the event more details are needed in order to treat my present condition.

---

Patient Signature

---

Date