Massage Therapy Initial Intake

Name:_____

Date:_____ **Birthdate:**_____

day/month/year day/month/year

Address& postal code:_____

_____

Care card or ICBC # if applic._____

Phone:_____**email:**_____

Referring physician:_____

Clinic Use only:

Circle any of the following conditions that apply to you:

pregnancy hypertension heart disease stroke or TIA kidney disease epilepsy

liver disease or hepatitis respiratory disease (incl. asthma) diabetes hearing loss

digestive disorder fractures or dislocations cancer nerve damage/numbness

HIV positive arthritis osteoporosis allergies eczema psoriasis

Do you have any medical conditions other than those listed above?

_____

Why have you come for massage?

_____

Please list current medications:

_____

_____

Please list any surgeries:

_____

note: please respect the time of your therapist and provide 24 hours notice of cancellation or a cancellation fee will be charged to the client. I authorize the clinic and its associated RMT's to communicate with my referring MD as deemed necessary for safe and effective treatment. I authorize the clinic to use the above contact information in order to leave messages regarding appointments. I understand my health history information will not be shared with others without my consent or court order.

Signature: