the health centre

British Columbia Registered Massage Therapists are part of the Health Care System, and this information is essential to ensure safe treatment, and an individualized, exceptional massage experience! Thank you, in advance for taking the time to fill out this form.

Patient Intake Form

Patient information contained within this form is considered strictly confidential.

Your responses are important to help us better understand the health issues you face and ensure the delivery of the best possible treatment.

Name: _____ **Date:** _____ (dd/mm/yr)

Insurance: _____

Date of Birth: _____ ☐ **male** ☐ **female**

Address: _____

_____

_____

Marital status

S	M	W	D	SEP

Phone #: home: _____ **work:** _____

E-mail address: _____

Occupation: _____ **Employer:** _____

Check ☑ and indicate the age when you had any of the following:

General
- ☐ Allergies
- ☐ Depression
- ☐ Dizziness
- ☐ Fainting
- ☐ Fatigue
- ☐ Fever
- ☐ Headaches
- ☐ Loss of sleep
- ☐ Mental illness
- ☐ Nervousness
- ☐ Tremors
- ☐ Weight loss / gain

Muscle / Joint
- ☐ Arthritis / rheumatism
- ☐ Bursitis
- ☐ Foot trouble
- ☐ Muscle weakness
- ☐ Low back pain
- ☐ Neck pain
- ☐ Mid back pain
- ☐ Joint pain

Skin
- ☐ Boils
- ☐ Bruise easily
- ☐ Dryness
- ☐ Hives or allergies
- ☐ Itching
- ☐ Rash
- ☐ Varicose veins

Eye, Ear, Nose & Throat
- ☐ Colds
- ☐ Deafness
- ☐ Ear ache
- ☐ Eye pain
- ☐ Gum trouble
- ☐ Hoarseness
- ☐ Nasal obstruction
- ☐ Nose bleeds
- ☐ Ringing of the ears
- ☐ Sinus infection
- ☐ Sore throat
- ☐ Tonsillitis
- ☐ Vision problems

Gastrointestinal
- ☐ Abdominal pain
- ☐ Bloody or tarry stool
- ☐ Colitis / Crohn's
- ☐ Colon trouble
- ☐ Constipation
- ☐ Diarrhea
- ☐ Difficult digestion
- ☐ Diverticulosis
- ☐ Bloated abdomen
- ☐ Excessive hunger
- ☐ Gallbladder trouble
- ☐ Hernia
- ☐ Hemorrhoids
- ☐ Intestinal worms
- ☐ Jaundice
- ☐ Liver trouble
- ☐ Nausea
- ☐ Painful deification
- ☐ Pain over stomach
- ☐ Poor appetite
- ☐ Vomiting
- ☐ Vomiting of blood

Genitourinary
- ☐ Bed-wetting
- ☐ Bladder infection
- ☐ Blood in urine
- ☐ Kidney infection
- ☐ Kidney stones
- ☐ Prostate trouble
- ☐ Pus in urine
- ☐ Stress incontinence

Urination
- ☐ Overnight more than twice
- ☐ More than 8x in 24hrs
- ☐ Decreased flow/force
- ☐ Painful urination
- ☐ Urgency to urinate

Cardiovascular
- ☐ High blood pressure
- ☐ Low blood pressure
- ☐ Hardening of the arteries
- ☐ Irregular pulse
- ☐ Pain over heart
- ☐ Palpitation
- ☐ Poor circulation
- ☐ Rapid heart beat
- ☐ Slow heart beat
- ☐ Swelling of ankles

Respiratory
- ☐ Chest pain
- ☐ Chronic cough
- ☐ Difficulty breathing
- ☐ Hay fever
- ☐ Shortness of breath
- ☐ Spitting up phlegm / blood
- ☐ Wheezing

Women only
- ☐ Congested breasts
- ☐ Hot flashes
- ☐ Lumps in breast
- ☐ Menopause
- ☐ Vaginal discharge

Menstrual flow
☐ Reg. ☐ Irreg. ☐ Pain / cramps
Days of flow: ____ Length of cycle: _____
Date - 1st day last period: _____
Are you pregnant? ☐ yes, ☐ no
If yes, how many months? _____
How many children do you have? _____
Birth control method: _____
Date of last PAP test: _____
☐ normal, ☐ abnormal
Date of last mammogram: _____
☐ normal, ☐ abnormal

Check any of the conditions you have or have had:
- ☐ Alcoholism
- ☐ Anemia
- ☐ Appendicitis
- ☐ Arteriosclerosis
- ☐ Asthma
- ☐ Bronchitis
- ☐ Cancer
- ☐ Chicken pox
- ☐ Cold sores
- ☐ Diabetes
- ☐ Eczema
- ☐ Edema
- ☐ Emphysema
- ☐ Epilepsy
- ☐ Goiter
- ☐ Gout
- ☐ Heart burn
- ☐ Heart disease
- ☐ Hepatitis
- ☐ Herpes
- ☐ High cholesterol
- ☐ HIV/AIDS
- ☐ Influenza
- ☐ Malaria
- ☐ Measles
- ☐ Miscarriage
- ☐ Multiple sclerosis
- ☐ Mumps
- ☐ Numbness/tingling
- ☐ Pace maker
- ☐ Osteoporosis
- ☐ Pneumonia
- ☐ Polio
- ☐ Rheumatic fever
- ☐ Stroke
- ☐ Thyroid disease
- ☐ Tuberculosis
- ☐ Ulcers

Please list any medication you are currently taking and why:

_____

_____

_____

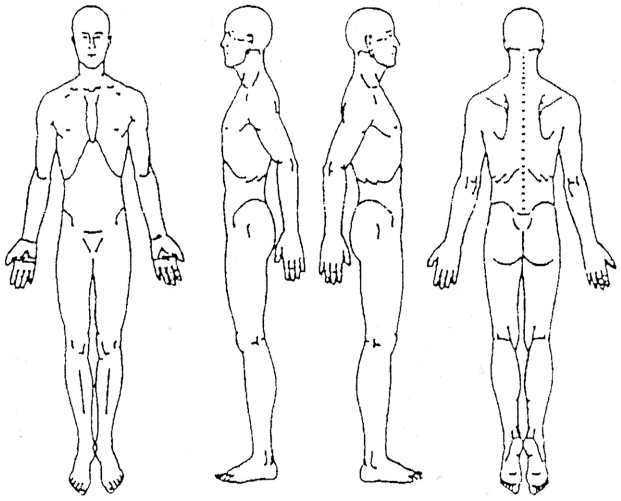
_____

How can I help you today? Why are you seeking massage therapy? *Please circle one:*

Relaxation **Stress Reduction** **Wellness** **Enjoyment**

Doctor Referral **Pain Relief** **Functional Issue** **Postural Issue** **ICBC/WCB**

Please Indicate the **TYPE** and **LOCATION** of symptom you are feeling in the appropriate area, using the indicators in the box to the right: (Feel free to overlap, and use multiple indicators)



P= pain

N= Numbness

T= Tingling

S= Sharp

A= Achy

D=Dull/Achy

Th= Throbbing

Br= Bright

Bu= Burning

When did it start? When was the **onset?** *Please circle the best estimate:*

1 2 3 4 5 6 7 8 9 10 11 Days ago Weeks Ago Months ago Years ago Unsure

Is there a known cause of this injury? Do you know **how** this happened?

_____

_____

Have you received a **diagnosis** from your Doctor for this condition? *Please circle one*:

Yes **No** If yes, please describe, to the best of your knowledge what the diagnosis is, and indicate, approximately when you were diagnosed:

_____
_____

Were you **hospitalized** for any injury/condition? *Please circle one:* **Yes** **No**
If yes, what was the hospitalization for? (Please also include the approximate date)

_____
_____

Please indicate below, any **history of injury**:

_____
_____
_____

What is the frequency of your symptom? **How often** does it happen?

_____

Please indicate the approximate **intensity** of your symptom out of 10.

***"1"**, meaning no pain, **"5"** meaning moderate pain, and **"10"** meaning the worst pain.*

At its best **/10** ***At its worst*** **/10** ***Now*** **/10**

When you experience the symptom, **how long does it last?** *(days, hours, minutes, seconds?)*

Is there any **time of the day** that your symptoms are worse? *Please circle one:*

Morning *Afternoon* *Night-time (disturbs sleep- Yes------No)*

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What seems to **aggravate** your symptoms? *Please also include any daily activities that are more difficult because of your condition:*

_____

_____

What seems to **alleviate** your symptoms? (heat, ice, rest, stretching etc)

_____

_____

Are you receiving any treatment from any other health-care professionals? Please circle one and/or write below:

Chiropractor Medical Doctor Naturopathic Doctor Massage Therapist Physiotherapist

Acupuncturist Chinese Medicine Other: _____

Is your current treatment **helping?** Please Circle one: **Yes** **No**

Have you had massage therapy before? Please Circle one: **Yes** **No**

If yes, how have you responded to Massage Therapy in the past? Please Circle one:

Favorably *Negatively* *No Response*

Please indicate any hobbies or exercise interests, for us to understand your activity level:

_____

_____

Lastly, please let us know if there is a type, or style of massage that you like/respond well to, or if there's a type, or style of massage that you react poorly to:

_____

_____