the IV 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.

RMT Intake Form

Today's Date _____

Name _____ Date of Birth (M/D/Y) _____

Address _____ City _____

Postal Code _____ Phone _____

Email _____ Occupation _____

Insurance _____ Employer _____

Primary Health Care Provider _____

Emergency Contact _____ Phone _____

Note: By providing your email address you are giving us consent to send you email confirmations for your appointments as well as The IV health centre's specials and newsletter.

Did someone refer you to the IV and if so, who? _____

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

General

- Allergies
- Depression
- Dizziness
- Fainting
- Fatigue
- 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
- Bruises easily
- Dryness
- Hives or allergies
- Itching
- Rash
- Varicose veins

Eye, Ear, Nose & Throat

- Colds
- Deafness
- Earache
- Eye pain
- Gum trouble
- Hoarseness
- Nasal obstruction
- Nosebleeds
- Ringing of the ears
- Sinus infection
- Sore throat
- Tonsilitis
- 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

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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 24 hours
- 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 heartbeat
- Slow heartbeat
- Swelling of ankles

Respiratory

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

Check any of the conditions you have or have had:

- Alcoholism
- Anemia
- Appendicitis
- Arteriosclerosis
- Asthma
- Bronchitis
- Cancer
- Chickenpox
- Cold sores
- Diabetes
- Eczema
- Edema
- Emphysema
- Epilepsy
- Goiter
- Gout
- Heart disease
- Hepatitis
- Herpes
- High cholesterol
- HIV / AIDS
- Influenza
- Malaria
- Measles
- Miscarriage
- Multiple sclerosis
- Mumps
- Numbness / tingling
- Osteoporosis
- Pacemaker
- Pneumonia
- Polio
- Rheumatic fever
- Stroke
- Thyroid disease
- Tuberculosis
- Ulcer

Women Only

- Congested breasts
- Hot flashes
- Lumps in breasts
- Menopause
- Vaginal discharge

Menstrual Flow

- Regular
- Irregular
- Pain / Cramps

Days of flow: _____

Length of cycle: _____

Date – 1st day of last period:

_____

Are you pregnant? Y / N

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

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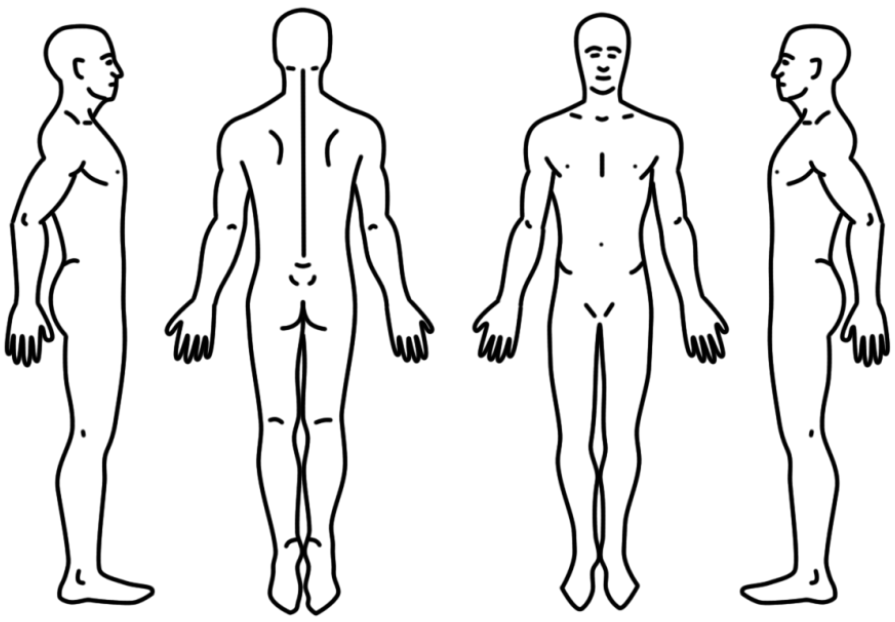
List all medications you are currently taking:

Medication	Daily Dose	How Long	Reason

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

Relaxation	Stress Reduction	Wellness
Enjoyment	Doctor Referral	Functional Issue
Pain Relief	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

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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? 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? 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, **"10"** meaning the worst pain.

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

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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?

Morning Afternoon Night-time

Do your symptoms disturb your sleep? Yes / No

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?

Chiropractor Medical Doctor Naturopathic Doctor Massage Therapist

Physiotherapist Acupuncturist Chinese Medicine Other: _____

Is your current treatment helping? Yes / No

Have you had massage therapy before? Yes / No

If yes, how have you responded to Massage Therapy in the past?

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: