

**PATIENT HISTORY**

**Date:** \_\_\_\_\_

**Birth Date:** \_\_\_\_\_  
Month / Day / Year

**Patients Name:** \_\_\_\_\_

First

Last

**Address:** \_\_\_\_\_

City \_\_\_\_\_ Province \_\_\_\_\_ Postal Code \_\_\_\_\_

Phone: \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_  
Home Work Cellular

E-mail address: \_\_\_\_\_

**How did you hear of our clinic?** Yellow Pages: \_\_\_\_\_ Referral: \_\_\_\_\_  
If yes, by whom were you referred by: \_\_\_\_\_

Medical Doctor: \_\_\_\_\_

Employer: \_\_\_\_\_ Occupation: \_\_\_\_\_

Address: \_\_\_\_\_  
City Prov. Postal Code

What are your reasons for treatment? \_\_\_\_\_

Please check if your **currently** receiving treatment from any of the following:

\_\_\_\_\_ Medical Doctor \_\_\_\_\_ Naturopath \_\_\_\_\_ Chiropractor \_\_\_\_\_ Physiotherapist \_\_\_\_\_ Other

Have you **previously** received Massage Therapy? Yes: \_\_\_\_\_ No: \_\_\_\_\_

If **yes**, this Clinic? \_\_\_\_\_ Other: \_\_\_\_\_

Have you ever had a **major** Surgery, Illness, or Accident? Yes: \_\_\_\_\_ No: \_\_\_\_\_

If yes, what? \_\_\_\_\_

Are you **currently** taking any medications? Yes: \_\_\_\_\_ No: \_\_\_\_\_

If **yes**, what type, and for what condition: \_\_\_\_\_

Do you smoke? Yes: \_\_\_\_\_ No: \_\_\_\_\_ If yes, how many per day?

Do you drink? Yes: \_\_\_\_\_ No: \_\_\_\_\_ If yes, how many drinks per week?

**How would you rate the amount of stress you are subject to?** \_\_\_\_\_

Please indicate on a scale of **1 to 10**, the extent to which you are currently satisfied with the following things: (**10** represents total **satisfaction**, **1** represents little or **no satisfaction**)

**Physical Health & Fitness** \_\_\_\_\_ **Mental & Emotional Happiness** \_\_\_\_\_  
**Energy** \_\_\_\_\_ **Diet** \_\_\_\_\_ **Ability to Relax** \_\_\_\_\_

**Please check, if you have, or had, to your knowledge, any of the following:**

Conditions	Present	Past	Conditions	Present	Past
Arthritis			Epilepsy		
Communal Disease			High Blood Pressure		
Specify:			Hemophilia		
Cancer			Kidney Disease		
Cardiovascular Disease			Rheumatism		
Diabetes			Other:		

✓ **Check any of the following conditions currently bothering you:**

**S = Slight M = Moderate I = Intense**

	S	M	I		S	M	I
Painful Muscle Tension				Digestive Problems			
Muscular Cramps				Stomach/Intestinal Ulcers			
Sore Aching Joints				Abdominal Cramps			
Frequent Cracking or Popping Sounds in Joints				Painful Bowel Movements			
Ligament Sprain				Menstrual Problems			
Muscle Strain				Pelvic Inflammation			
Joint Dislocation				Urinary Infection			
Pain on Walking				Prostate Infection			
Flat Feet				Frequent Colds or Flu			
Sore Feet				Allergies			
Painful Legs				Asthma			
Painful Arms Pain				Low Blood Pressure			
Low Back				Frequent Cold Hand/Feet			
Mid-Back Pain				Bruise Easily			
Upper Back/Shoulder Pain				Varicose Veins			
Neck pain				Anxiety			
Headache				Depression			
Skin Infection				Constant Irritability			
Psoriasis				Unexplained or Sudden Weakness			
Eczema				Any other Conditions not listed?			

In case of emergency who can we contact? Please list two (2) people with their available phone numbers.

1) \_\_\_\_\_ 2) \_\_\_\_\_

**Please note: there is a charge of Half price for any missed scheduled massage treatments without providing 24 Hour notice to our office. There is a \$15.00 charge for any NSF or returned cheques, and the fee from our Banking institution. You will be sent an invoice for these Charges, and you will have 15 days to pay your outstanding balance.**

**The information contained on this form is true to the best of my knowledge. Intrinsic Massage Therapy will be the sole trustee of your file and all personal information within, as per the guidelines in The Personal Information Protection Act (abbreviated PIPEDA or PIPED Act).**

\_\_\_\_\_  
**Signature**

\_\_\_\_\_  
**Date**

I give my permission that my therapist may obtain and submit reports regarding my condition to/from my Physician, Chiropractor, Physiotherapist, Podiatrist, and/or, Attorney as required.

\_\_\_\_\_  
**Signature**

\_\_\_\_\_  
**Date**