FALL RIVER
COLLABORATIVE HEALTH CARE

Massage Intake Form

Personal Information

Name: _____
Last Name First Name Middle Initial Pronouns (He/She/they)

DOB: _____
Year Month Day Height Weight

Address: _____
Street City Postal

Phone Number: _____
Home Cell Work

Occupation: _____ Employer: _____

Medical Doctor: _____ Health Card Number: _____

Emergency Contact (Name and Number): _____

How did you hear about our office?
( ) Patient referral ( ) Road sign ( ) Google search ( ) Social Media ( ) Another Practitioner ( ) Other

If other, tell us how: _____

Are you currently seeing the following?
( ) Physiotherapy ( ) Chiropractor ( ) Acupuncturist ( ) Osteopath ( ) Naturopathic Doctor
( ) Personal Trainer ( ) Other Specialist

If other, Who? _____

What is bothering you today? _____

Describe the onset of your symptoms: _____

How long have you had your symptoms/pain? _____

How would you describe your pain or symptoms?
( ) Aching ( ) Stabbing ( ) Shooting ( ) Numbness ( ) Tingling ( ) Throbbing ( ) Other

Please list what areas: _____

Have you had treatment for this condition in the past?
( ) Yes ( ) No

If yes, How long ago: _____

On a scale of 0-10 (0 being none, and 10 being deliberating) how bad is your pain: _____

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General Health

List any current medications or supplements (including birth control) and doses if possible:

_____

Do you smoke (including cigars and marijuana)
( ) Yes ( ) No

Do you exercise?
( ) No ( ) 1-2x per week ( ) 3-5x per week ( ) >5x per week

Have you had any hospitalizations?
( ) yes ( ) No

If yes, explain: _____

Have you had any fractures or dislocations?
( ) Yes ( ) No ( ) Unknown

If yes, where? List all: _____

Please list any surgical implants (pins, plates, wires, pacemaker, artificial joints, etc.)

_____

Have you ever had any of the following?
( ) Muscle strain ( ) Ligament sprains/tears ( ) Herniated disc ( ) Whiplash ( ) Lock jaw

If checked, explain: _____

Are you experiencing pain in any of the following?
( ) Headache ( ) Jaw ( ) Neck ( ) Mid back ( ) Low back ( ) Pelvis ( ) Abdomen ( ) Chest
( ) Right shoulder ( ) Left shoulder ( ) Right arm ( ) Right elbow ( ) Left elbow ( ) Left arm ( ) Left wrist
( ) Right wrist ( ) Right hip ( ) Left hip ( ) Right leg ( ) Left leg ( ) Right knee ( ) Left knee ( ) Right foot
( ) Left foot

Neuromuscular skeletal
( ) Grinding/clenching teeth ( ) Swollen joints ( ) Numbness ( ) Tremors ( ) Scoliosis
( ) Osteo Arthritis ( ) Rheumatoid Arthritis ( ) Psoriatic Arthritis ( ) Osteoporosis ( ) Carpal Tunnel
( ) Other

If other, explain: _____
Skin/Allergies
( ) Allergies ( ) Bruise easily ( ) Psoriasis ( ) Eczema ( ) Rashes or irritation ( ) Shingles
( ) Fungal infection ( ) Skin sensitivities ( ) Cancer

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Cardiovascular
( ) Heart attack ( ) High blood pressure ( ) Low blood pressure ( ) High cholesterol ( ) Angina
( ) Stroke ( ) TIA ( ) Blood clots ( ) Varicose veins ( ) Irregular heart beat/murmur ( ) Bypass Surgery
( ) clotting issues ( ) Hemophilia ( ) pacemaker ( ) Other heart issues

If other, explain: _____

Respiratory
( ) Asthma ( ) COPD ( ) Emphysema ( ) Difficulty breathing ( ) Chronic cough ( ) Chest pain
( ) Wheezing ( ) Other

If other, explain: _____

Digestive
( ) IBS ( ) Crohn's ( ) Colitis ( ) Diverticulitis ( ) Reflux ( ) Ulcers ( ) Celiac ( ) Hernia ( ) Gall stones
( ) Constipation ( ) Gas or bloating issues ( ) Nausea/vomiting ( ) Other

If other, explain: _____

Urinary
( ) Frequent Urination ( ) Inability to control ( ) Regular bladder/kidney infections ( ) Kidney stones
( ) Prostate issues ( ) Other

If other, explain: _____

Reproductive
( ) Pregnant ( ) Miscarriage ( ) C-section ( ) Irregular or painful periods ( ) Pre, peri or post menopause
( ) Infertility issues ( ) Pain with intercourse ( ) Endometriosis ( ) PCOD ( ) Testicular issues
( ) Prostate issues ( ) Vasectomy ( ) Other

If other, explain: _____

Mental Health
( ) Depression ( ) Anxiety ( ) OCD ( ) Seasonal Affective Disorder ( ) Personality Disorder ( ) Suicidal
( ) Schizophrenic ( ) Other

If other, explain: _____

Ears, nose, throat
( ) Allergies ( ) Hay fever ( ) Ear infections ( ) Trouble swallowing ( ) Sinus congestion/infections
( ) Strep throat ( ) Other

If other, explain: _____

Neurological
( ) Dizziness ( ) Loss of consciousness ( ) Vertigo ( ) Concussions ( ) Stroke ( ) TIA
( ) Visual disturbance ( ) Twitching ( ) Balance issues/clumsiness ( ) Speech difficulties ( ) Tremors
( ) Fainting ( ) Paralysis ( ) Bells Palsy ( ) Multiple Sclerosis ( ) Seizures ( ) Other

If other, explain: _____

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Other
( ) Diabetes ( ) Thyroid issues ( ) HIV Positive ( ) Other STD ( ) Alcoholism ( ) Drug Addiction
( ) Fibromyalgia ( ) Chronic Fatigue Syndrome ( ) Chronic Pain Syndrome

Please list any other health conditions

_____

Please tell us about anything that feel we need to know in regard to your health that we may have missed: _____

Massage Preferences

Are there areas that you DO NOT want massaged/touched?

( ) Scalp ( ) Chest ( ) Glutes ( ) Face ( ) Abdomen ( ) Sides ( ) Feet ( ) Other

If other, explain: _____

Are you okay with music during your session?
( ) Yes ( ) No ( ) Sometimes

Would you like to add aromatherapy to your session?
( ) No ( ) Yes, diffused in air ( ) Yes, used in oil

If yes, do you have a preferred scent (note, these are high quality essential oils)
( ) Lavender ( ) Peppermint ( ) Eucalyptus ( ) Cedar wood ( ) Other

If other, explain: _____

Would you like to chat during your massage?
( ) Yes ( ) No ( ) Depends on the day

Do you like heat added to your massage?
( ) Yes ( ) No

Which additional therapies are you comfortable with during your session?
( ) Cupping ( ) Myofascial release (massage with movement of area) ( ) Stretching
( ) Home care exercises ( ) Intra-oral Jaw work ( ) Cranial Sacral Therapy ( ) Biofreeze

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Treatment Consent

I consent to massage therapy treatments as described by the prescribed therapist. I also verify that the information given on this form is true and reflects my past and present health status. Should there be any changes in my health I will inform my therapist before treatment.

I understand that massage therapists do not diagnose illness or prescribe medications, and that my treatment will be in the context of relaxation, relief of muscular tension or pain, and improving circulation.

( ) I agree to the terms above

Sensitive area Massage Consent

I have requested assessment and/or treatment by the RMT for treatment of the areas listed below:
I give special consent to the following areas being treated.
( ) Glute/Buttocks area ( ) Breast Tissue ( ) Chest wall without breast tissue ( ) Upper Inner Thigh
( ) Abdomen

I Understand that this consent can be withdrawn or altered at any point.

( ) I agree to the terms above

I consent to the above:

Signature: _____

Payment and late arrival Policy

I agree to pay for all scheduled appointments that I am unable to keep unless I notify my massage therapist at least 24 hours in advance.
Should I arrive late I will pay for a full session although it will end at the original scheduled time. Only the portion of the massage attended can be direct billed. The additional time will be at my expense.

( ) I agree to the above terms

Privacy policy

We are committed to protecting the privacy of all individuals providing personal and medical information to us, including the data recorded by our patients in our online system. Your information is stored on a remote server specifically protected for medical records.
Your information entered is shared only with the clinic and all medical information is kept confidential. Medical information is only visible to the practitioners of the clinic. Personal information will be entered into our system strictly for the use of keeping medical records and to be able to contact you directly. Your information will never be shared with outside parties.

( ) I agree to the above privacy policy