Registered Massage Therapy

Intake Form

Name: _____ Date: _____

Date of Birth: D___ M___ Y_____ Home Phone: _____ Cell Phone:_____

Email: _____

Mailing Address: (Street)_____

(City) _____ (Province) _____ (Postal Code)_____

How were you referred to The Lifehouse?

_____

What is your major concern or condition you want to improve? When did you first notice this?

_____

_____

Did anything initiate this problem? What kind of daily activities aggravate this?

_____

_____

What do you do in order to get relief?

_____

_____

What are you hoping to accomplish throughout this treatment?

_____

_____

Who are you getting medical/therapeutic care from at this time?

_____

_____

Medications/supplements? Regular physical activity? Daily life activities

_____

_____

Health History

Circle any conditions or injuries you may have or have had:

Back or hip pain
Shoulder, neck, arm or hand pain
Leg or foot pain
Chest, rib, or abdominal pain
Jaw or TMJ pain
Joint stiffness or swelling
Numbness and tingling
Spasms or cramps
Spinal cord injury
Broken or fractured bones
Strains or sprains
Headaches
Fatigue
Sleep deprivation
Dizziness, shortness of breath, fainting
Cold sweats, cold feet, or hands
Face twitch
Indigestion or diabetes
Constipation or diarrhea
Bloating
Bladder infection
Allergies
Arthritis
Warts or rashes
Infectious disease
Hearing or visually impaired
Stroke, heart condition, high/low blood pressure
Varicose veins or blood clots, or swollen ankles
Osteoporosis
Depression, anxiety or difficulty concentrating
Tendonitis or bursitis
Scoliosis, or other bone and joint diseases
Ulcer, herpes/shingles
Cancer
Endometriosis
Crohn's, Colitis, IBS
Paralysis, Cerebral Palsy, Epilepsy
Chronic fatigue syndrome or Fibromyalgia
MS, Muscular Dystrophy or Parkinson's
Menopause
Any surgeries
Other (please describe below)

Are you pregnant? _____

Other relevant health information or details of the above conditions:

_____

_____

I have stated all conditions in my health history that I am aware of and this information is true and accurate. I will inform the health care provider, including massage therapist, of any chances in my status.

Signature _____ Date _____