ISM REHAB
INNOVATION SCIENCE & MEDICINE

Massage Therapy Patient Intake Form

All information is retained as part of your confidential patient record

Health History

The information request below will assist us in treating you safely. Feel free to ask any questions about the information being requested. Please note that all information provided below will be kept confidential unless allowed of required by law. Your written permission will be required to release any information

First Name: _____ *Preferred Name*: _____Last Name: _____

Date of Birth: Year_____ Month____ Day_____ Home #: _____ Cell #: _____

Email: _____ Street Address: _____ Apt/Unit#: _____

City: _____ Province: _____ Postal Code: _____ Family Physician: _____

Referring Physician: _____ Occupation: _____

Emergency Contact: _____ Relationship: _____ Phone #: _____

Reason for Treatment: _____

Please list any surgeries (including internal pins/wires/artificial joints), past injuries or major dental work you've had:

_____

Please list your current medications (may also provide us a list of your current medications):

_____

How did you hear about us?

O *Doctor* O *Webpage* O *Social Media* O *Friend / Family* O *Google* O *Location* O *Other*

Coverage: O None O Third Party Insurance O Motor Vehicle Claim

Third Party Insurance

Provider: _____ Policy Holder Name *(as presented on card):* _____

Policy Holder Relationship: O Self O Spouse/ Domestic Partner O Parent/ Guardian

Policy Holder Date of Birth: Year_____ Month_____ Day_____ **Do you consent to electronic billing? O Yes O No**

Policy #: _____ ID/Certificate #: _____

Are you currently receiving or have ever received any of the following treatments for your current condition(s)?

O Physiotherapy O Massage Therapy O Chiropractic O Acupuncture O Occupational Therapy

O Naturopathic O Podiatry/ Chiropody O Other: _____

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Please indicate any conditions you are currently experiencing or have experienced:

Cardiovascular

- ☐ High Blood Pressure
- ☐ Low Blood Pressure
- ☐ Chronic Congestive Heart Failure
- ☐ Heart Attack
- ☐ Heart Disease
- ☐ Heart Palpitations
- ☐ Heart Murmur
- ☐ Stroke
- ☐ Aneurism
- ☐ Blood Clots
- ☐ Raynaud's Disease
- ☐ Phlebitis/ Varicose Veins
- ☐ Poor Circulation
- ☐ Pacemaker

Respiratory

- ☐ Chronic Cough
- ☐ Shortness of Breath
- ☐ Bronchitis
- ☐ Asthma
- ☐ Pneumonia
- ☐ Tuberculosis
- ☐ Sinusitis
- ☐ Sinus Congestion
- ☐ Do you smoke? __Yes__No

Blood

- ☐ Anaemia
- ☐ Haemophilia
- ☐ Leukemia
- ☐ Hepatitis: A___ B___ C ___

Gastrointestinal

- ☐ Constipation
- ☐ Diarrhea
- ☐ Gas/ Bloating
- ☐ Nausea/ Vomiting
- ☐ Irritable Bowl Syndrome
- ☐ Crohn's/ Colitis
- ☐ Hernia
- ☐ Ulcers
- ☐ Gall Bladder Problems
- ☐ Liver Problems
- ☐ Difficulty/ Frequent Urination
- ☐ Poor Appetite
- ☐ Excessive Thirst

Skin

- ☐ Allergies: _____
- ☐ Hypersensitivity
- ☐ Bruise Easily
- ☐ Rashes: _____
- ☐ Eczema
- ☐ Psoriasis
- ☐ Athletes Foot
- ☐ Herpes
- ☐ Warts
- ☐ Skin Conditions: _____

Women

- ☐ Pregnant, Due: _____
- ☐ Infertility
- ☐ Menstrual Concerns/ Pain
- ☐ Hysterectomy
- ☐ Endometriosis
- ☐ Fibroids

Muscle/ Joint

- ☐ Muscle Strain
- ☐ Ligament Sprain
- ☐ Spasms/ Cramps
- ☐ Tendinitis
- ☐ Bursitis
- ☐ Fibromyalgia
- ☐ Ankylosing Spondylitis
- ☐ Osteoporosis
- ☐ Herniated Disc
- ☐ Degenerative Discs
- ☐ Joint or Bone Disease
- ☐ Scoliosis
- ☐ Dislocation
- ☐ Fracture

Other

- ☐ Diabetes, Onset: _____
- ☐ AIDS/ HIV
- ☐ Cancer: _____
- ☐ Multiple Sclerosis
- ☐ Epilepsy
- ☐ Thyroid Disorders
- ☐ Lupus
- ☐ Loss of Sensation: _____
- ☐ Insomnia/ Fatigue
- ☐ Depression
- ☐ Alcohol/ Drug Addiction
- ☐ Headaches
- ☐ Migraines
- ☐ Whiplash
- ☐ Jaw Pain
- ☐ Ear Pain/ Infections
- ☐ Difficulty with Hearing
- ☐ Vision Loss/ Difficulty

Lifestyle: Rate 1 – 5 **(5 is high)**
Regular Exercise: _____
Water Intake: _____

8 Hours of sleep: _____
Water Intake: _____

Good Eating Habits: _____
General Health: _____