



PHYSIOTHERAPY  
&  
REGISTERED MASSAGE THERAPY  
CLINIC

### Massage Therapy Patient Intake Form

Please take time to fill out this confidential form. It allows us to design a safe and effective treatment for you, working towards your health goals. Our privacy posted is posted on our website: we will only release this information with your consent, except as required by law. If any of your health or contact information changes in the future, please let us know so that we can continue to work together safely and effectively.

Name: \_\_\_\_\_

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

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

Date of Birth: \_\_\_\_\_ Sex: F [ ] M [ ]

Home Phone: \_\_\_\_\_ Alternate Phone: \_\_\_\_\_

Email Address: \_\_\_\_\_

Employer: \_\_\_\_\_ Work Phone: \_\_\_\_\_

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

Emergency Contact: \_\_\_\_\_ Phone: \_\_\_\_\_

Physician: \_\_\_\_\_ Phone: \_\_\_\_\_

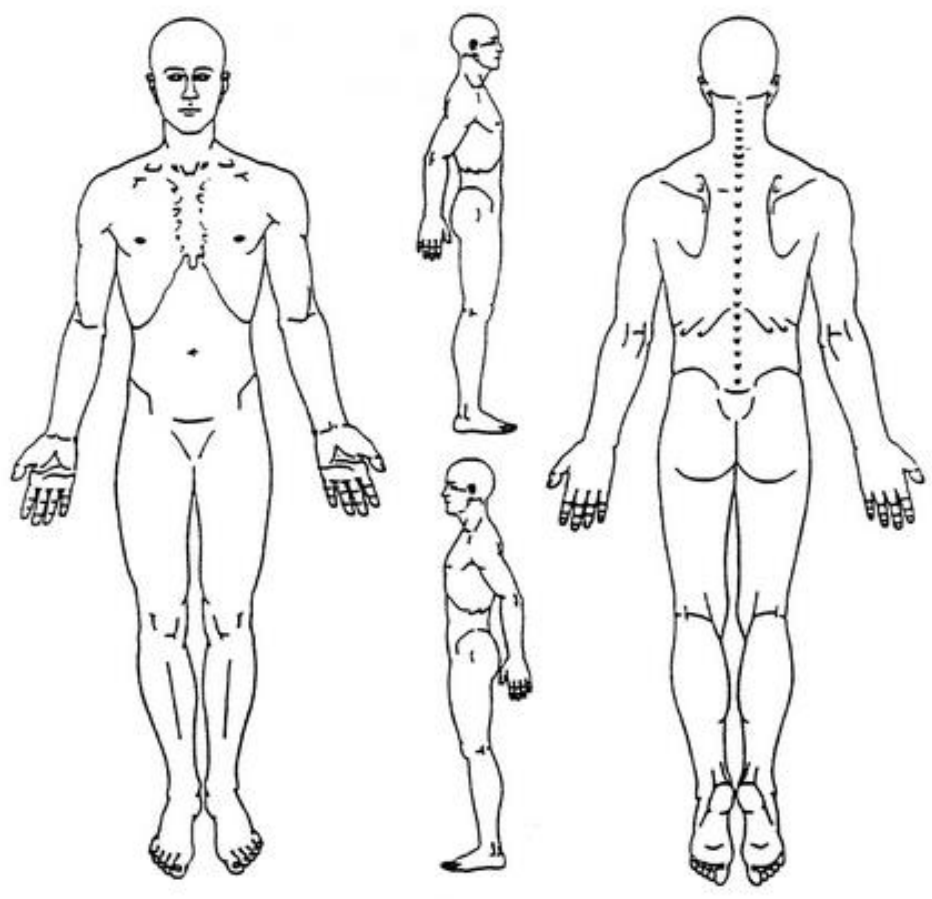
How did you hear about us? \_\_\_\_\_ Is this your first massage? Yes [ ] No [ ]

Please list the treatments or medications you have used or taken in the last 24 hours:

Please list any other medications you are taking and the conditions they treat:

Please list any allergies:

Please circle any areas on your body where you would like to feel more comfortable today:



History of accidents and injuries (ex: serious sprain or fall, motor vehicle accident, broken bones):

History of surgeries:

Name and full contact of MD/Care Provider (name, address, phone number):

Please check all of the following conditions that affect you:

#### Blood and Cardiovascular

- Chronic congestive heart failure
- Heart attack
- Heart disease
- Blood pressure – High or Low (circle one)
- Pacemaker or similar device
- Phlebitis or varicose veins
- Stroke/Cardiovascular Accident (CVA)
- Hemophilia

#### Respiratory

- Bronchitis
- Asthma
- Chronic cough
- Emphysema
- Shortness of breath

#### Infections

- Hepatitis
- HIV
- Herpes
- Lyme Disease
- Tuberculosis

#### Head and Neck

- Hearing problems
- History of headaches
- Vision problems
- History of migraine
- Tinnitus

#### Musculoskeletal

- Osteoporosis
- Osteoarthritis
- Rheumatoid Arthritis
- Scoliosis

#### Nervous System

- Epilepsy
  - Multiple sclerosis
  - Mental health concerns:
- 

#### Other

- Anemia (Low iron)
  - Diabetes
  - Cancer
  - Digestive Conditions
  - Endometriosis
  - Fibromyalgia
  - Lupus
  - Skin conditions:
- 

- Thyroid condition: High or Low (circle one)
  - Tingling or loss of sensation in:
- 

- Allergies or hypersensitivity to:
- 

- If pregnant, when are you due? \_\_\_\_\_

Is there a family history with any of the above conditions?  Yes  No

Briefly, which one: \_\_\_\_\_

Do you have any internal pins, wires, artificial joints or special equipment?  Yes  No

If yes, please explain: \_\_\_\_\_

Is there anything else we should know about your health before we begin our treatment?  Yes  No

If yes, please explain: \_\_\_\_\_

**What are the physical duties required of your occupation?**

**Have you ever received therapeutic massage for a specific problem or injury?  Yes  No**

If yes, please specify the problem or injury:

**Is there anything that you do that creates, increases, or decreases pain?  Yes  No**

If yes, please specify:

In what position do you most often wake up?  Back  Side  StomachAre you currently seeing any other healthcare professional?  Yes  No

Please check any symptoms that apply to you and indicate RIGHT or LEFT when applicable:

**Head**

- Temples  Forehead  Top of head  In the eyes  Entire head  Base of skull  
 Dizziness  Fainting  Light-headedness  Pain in ears  Ringing in ears

**Neck**

- Stiffness  Pain at neck/shoulder junction  Pain when turning head  Muscle spasms in neck  
 Pain with side to side movements  Neck feels out of place  Diagnosed bone spurs  
 Gliding/grating sound with neck movement  Diagnosed disc herniation

**Arms & Hands**

- Pain in shoulder  Pain in forearm  Pain in wrist  Pain in fingers  Sensation of pins and needles in arm  Sensation of pins and needles in fingers  Fingers go to sleep  Hands cold  
 Swollen joints in fingers  Sore joints in fingers  Diagnosed arthritis  Loss of grip strength

**Shoulders**

- Pain in upper arm  Back  Side  Pain deep in shoulder joint  Diagnosed bursitis  
 Diagnosed Arthritis  Can't raise arm above shoulder level  Can't raise arm overhead

**Mid-Back**

- Mid-back pain  Pain between shoulder blades  Pain up/down back  Pain across mid-back  
 Pain with breathing

**Lower Back**

- Lower back pain  Lower back in pain is worse when working  Lower back pain is worse when lifting  Lower back pain is worse when stooping  Lower back pain is worse when standing  
 Lower back pain is worse when sitting  Lower back pain is worse when bending  Lower back

pain is worse when coughing  Pinched nerve in low back  Lower back feels out of place  
 Pain up/down low back  Pain across lower back  Diagnosed disc herniation

### Hip

Pain in buttocks  Pain in buttocks when standing  Pain in buttocks when sitting  Pain on side of hip  
 Pain deep in hip joint  Pain on sit bone  Diagnosed bursitis  Diagnosed arthritis

### Legs and Feet

Pain down RIGHT leg  Pain down LEFT leg  Pain down BOTH legs  Leg cramps  
 Pin & Needles in RIGHT leg  Pin & Needles in LEFT leg  Numbness in RIGHT leg  Numbness in LEFT leg  
 Numbness in RIGHT foot  Numbness in LEFT foot  Numbness in toes  Feet feel cold  
 Cramps in RIGHT foot  Cramps in LEFT foot  Swollen RIGHT ankle  Swollen LEFT ankle  
 Swollen RIGHT foot  Swollen LEFT foot  Pain in RIGHT foot  Pain in LEFT foot  Pain in RIGHT knee  
 Pain in LEFT knee  Diagnosed arthritis

### Client Agreement

I understand that massage therapists do not diagnose illness, disease, any physical or mental disorder, nor do they prescribe medical treatment, or pharmaceuticals.

I acknowledge that massage therapy is not a substitute for medical examination or diagnoses, and it is recommended that a physician be seen for that service.

It is my choice to receive therapeutic massage as a form of therapy.

I understand that a treatment given is designed to address the care and prevention of myofascial pain and dysfunction.

I also understand that at any time I feel pain or discomfort during the session, I will immediately inform my massage therapist so they adjust.

I have stated my pertinent medical conditions, and will update the massage therapist of any changes in my health status.

I understand that my failure to do so may pose a threat to my health and physical well-being and I hold harmless First Care Physiotherapy & Massage Therapy Clinic and my massage therapist from any liability whatsoever arising from failure on my part.

By my signature below, I agree to the massage policy and client agreement above.

---

Client Signature

---

Date

T: (905) 453.3883      F: (905) 453.2882  
 Email: [admin@firstcarephysiotherapy.com](mailto:admin@firstcarephysiotherapy.com)  
 Visit us: [www.firstcarephysiotherapy.com](http://www.firstcarephysiotherapy.com)

257 Main Street North  
 Brampton, Ontario  
 L6X 1N3

*We care, because it's your health!*