



Message Therapy New Patient Form

Mr. Mrs. Miss Ms. Dr.

First Name: _____ Last Name: _____

Date of Birth: Month _____ Day _____ Year _____ Gender: F M

Street Address: _____ City: _____

Province: _____ Postal Code: _____

Email: _____ Occupation: _____

Phone: Home: _____ Work: _____

Cell: _____ (Please indicate which, if any, we can leave a message at)

Emergency Contact: _____ Phone: _____

Family Physician's Name: _____ Phone: _____

How did you hear about us? _____

Do you have private healthcare insurance? Yes or No If yes, which company? _____

Please provide your insurance card so that we may obtain a photocopy for our records

Please list any PAST surgeries / injuries / accidents and the corresponding dates:

Are you currently undergoing any forms of treatment (including medications)? Please list details:

Please circle only those conditions that apply to you:

- | | | | |
|------------|--------------------------|--|----------------------|
| Hemophilia | Immunological Disease | Abdominal / Digestive Disease | Multiple sclerosis |
| Stroke | Undiagnosed Lump | Numbness or Loss of Sensation | Osteoporosis |
| Aneurysms | Dizziness / Fainting | High Blood Pressure | Breathing Difficulty |
| Epilepsy | Rheumatoid Arthritis | Osteoarthritis | Joint Instability |
| Diabetes | Irritable Skin Condition | Surgical Implants (pins, metal plates, pacemaker, other) | Cancer |

Are you pregnant? Yes or No

Confidentiality Statement:

I certify that the information voluntarily given here is true and accurately reflects my understanding of my past and present health status. I will inform the massage therapist of any changes in regards to my health. I understand that this information is a CONFIDENTIAL Medical Record that is protected by Active Approach Health and Wellness Centre and its' registered massage therapists. I understand that therapeutic massage is intended to enhance relaxation, reduce pain caused by muscle tension, increase range of motion, and offer a positive experience of touch. I am aware that the therapist does not diagnoses illness or disease, cannot prescribe medications, and that high velocity joint manipulations are not part of massage therapy.

Cancellation Policy:

Twelve (12) hours notice, outside of illness or emergency, is required for cancellation. A fee of 100% of the treatment may be payable on cancellations without adequate notice and "no shows."

I have read the above, and agree and understand that I am responsible for all charges relating to my visit.

Signature: _____ Date: _____

ASSESSMENT INFORMATION

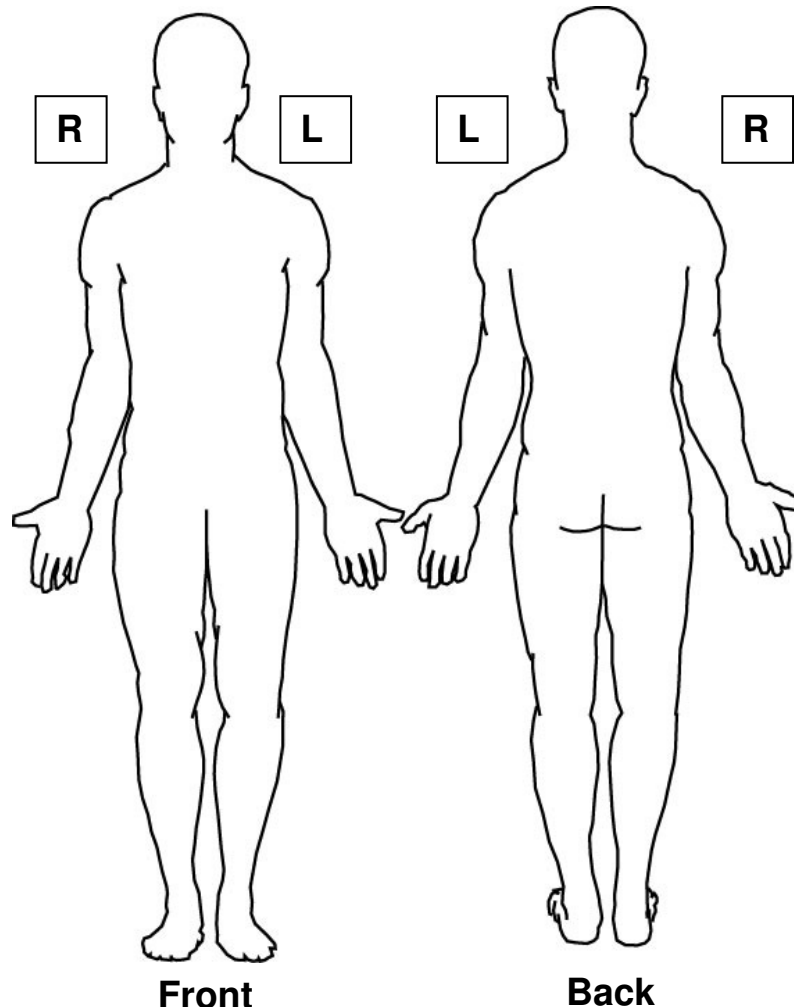
- Location of pain (please use the diagrams and symbols below – be as specific as possible)
- Does the pain radiate to other areas? If yes, please indicate on the diagram below, again being as specific as possible.
- Cause of the pain: _____
- How long have you had the pain? _____
- How frequent is the pain? Constant Daily _____
- On a scale of 1 (minimal) to 10 (extreme), how intense is the pain? _____
- How would you describe the pain? Achy Throbbing Burning _____
- What makes the pain go away/decrease? Rest Heat Ice Exercise _____
- What makes the pain increase? Activity Prolonged Sitting _____
- Are you presently taking any medications for your condition? (i.e. muscle relaxants, anti-inflammatories, pain killers) _____
- Is there a history of this condition in your family? _____
- Have you received any other treatment for this condition? If yes, please describe and comment on its success _____

Please use the following symbols on the diagrams below to illustrate your symptoms

PAIN ///////////////

RADIATING PAIN 

NUMBNESS + + + + + + +



PLEASE PRINT AND BRING ALL COMPLETED FORMS WITH YOU FOR YOUR INITIAL MASSAGE

Please be advised that if you see more than one practitioner in our office,
your health information will be shared only with the practitioners providing treatment to you.