Vive Integrative Health Group

Megan Lundrigan, RMT
www.vivehealth.ca

MASSAGE INTAKE FORM

Name: ____

Address: ____

City: ____________________ Province: _________ Postal Code: ______________

Phone (Home): ________________ (Work): ______________ (Cell): ______________

E-mail: ____________________ Would you like to receive our newsletter by email? yes ❑

Male ❑ Female ❑ Age: __________ Date of Birth: ______________________

Marital Status: ________________ Number of children: ______________________

Occupation: __________________ Employed By: ______________________

Emergency Contact: ______________ Phone: ______________ Relation: ____________

Name of Medical Doctor: ______________________ Phone: ________________

How did you hear about our practice? ______________________________

CONTEXT OF CARE

What is your current health concern?

____

____

Describe your symptoms and when they began:

____

____

Are you currently under the care of other health care providers for this concern? yes❑ no❑

If yes, please provide the name of the doctor, the diagnosis and type of care you are receiving:

____

____

____

List any past injuries and/or surgeries and their dates:

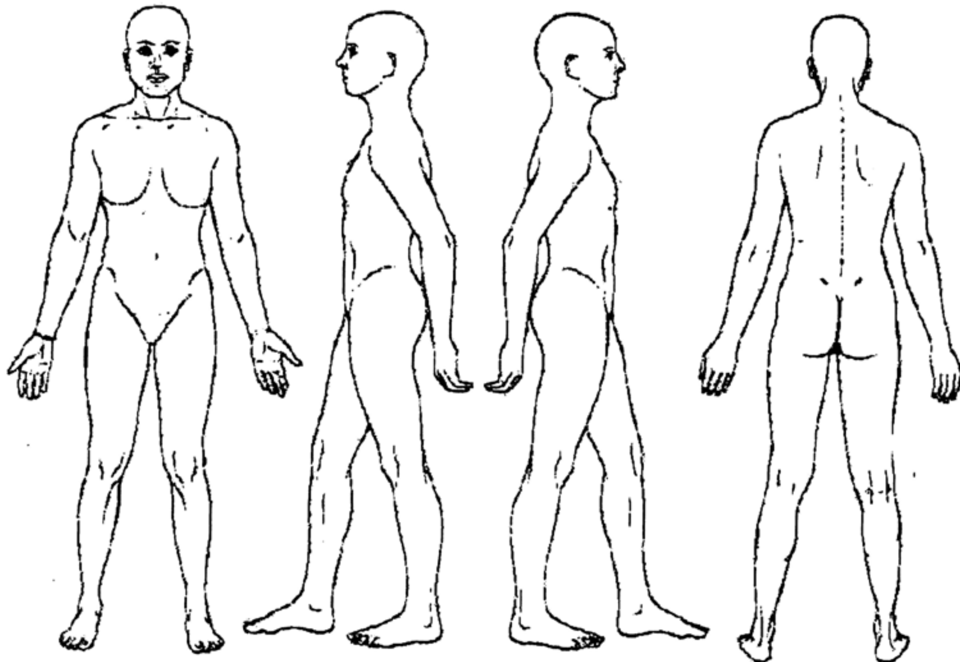
____

____

____

LOCATIONS OF PAIN OR DISCOMFORT

Please mark the location of any pain or discomfort on the sketches below.



GENERAL REVIEW

Please list any medications or supplements you are taking:

____

____

____

____

What types of exercise do you do? (Indicate how often and how long)

____

____

____

____

How many hours do you work each day? ____

Do you enjoy your work? ____

Do you often feel overworked? yes❑ no❑

Rate your energy between 1 and 10. (low) 1 2 3 4 5 6 7 8 9 10 (high)

Rate your stress between 1 and 10. (low) 1 2 3 4 5 6 7 8 9 10 (high)

Please check "✓" any of the following that apply to you or write "P" beside the box if you have experienced these in the past.

General

- ❑ Fatigue
- ❑ Change in appetite
- ❑ Change in thirst
- ❑ Weight gain
- ❑ Weight loss
- ❑ Poor sleep
- ❑ Chills or fever
- ❑ Night sweats
- ❑ Sweat easily
- ❑ Allergies
- ❑ Cancer
- ❑ Diabetes

Skin

- ❑ Scars
- ❑ Dryness
- ❑ Rash
- ❑ Itching
- ❑ Eczema
- ❑ Psoriasis
- ❑ Acne
- ❑ Recent moles
- ❑ Hives or allergic reactions
- ❑ Other skin problems

Eyes Ears Nose & Throat

- ❑ Eye pain
- ❑ Eye strain
- ❑ Blurry vision
- ❑ Impaired vision
- ❑ Cataracts
- ❑ Ear aches
- ❑ Ear infections
- ❑ Ringing in ears
- ❑ Vertigo or dizziness
- ❑ Sinus infections
- ❑ Nasal obstruction
- ❑ Post nasal drip
- ❑ Nosebleeds
- ❑ Loss of smell/taste
- ❑ Jaw pain or clicks
- ❑ Enlarged glands
- ❑ Enlarged thyroid
- ❑ Facial pain/tics
- ❑ Headaches

Cardiovascular

- ❑ Chest pain
- ❑ Palpitations
- ❑ High blood pressure
- ❑ Low blood pressure
- ❑ Heart attack
- ❑ Congestive heart failure
- ❑ Irregular heartbeat
- ❑ Pacemaker
- ❑ Artificial heart valve
- ❑ Stroke
- ❑ Fainting
- ❑ Varicose veins
- ❑ Deep leg pain
- ❑ Cold hands or feet
- ❑ Swelling of limbs
- ❑ Anemia
- ❑ Easy Bruising

Respiratory

- ❑ Difficulty breathing
- ❑ Shortness of breath
- ❑ Chronic cough
- ❑ Bronchitis
- ❑ Emphysema
- ❑ Asthma
- ❑ Wheezing
- ❑ Coughing blood
- ❑ Phlegm in throat

Muscle Bone & Joints

- ❑ Neck pain
- ❑ Back pain
- ❑ Arthritis
- ❑ Bursitis
- ❑ Joint pain or stiffness
- ❑ Artificial joint
- ❑ Muscle pain
- ❑ Muscle weakness

Gastrointestinal

- ❑ Nausea
- ❑ Vomiting
- ❑ Vomiting blood
- ❑ Reflux or heartburn
- ❑ Ulcer
- ❑ Indigestion
- ❑ Gall stones
- ❑ Liver disease
- ❑ Jaundice
- ❑ Intestinal parasites
- ❑ Constipation
- ❑ Diarrhea
- ❑ Chronic laxative use
- ❑ Rectal burning/pain
- ❑ Hemorrhoids
- ❑ Blood in stool
- ❑ Other digestive problems

Neurological

- ❑ Anxiety
- ❑ Depression
- ❑ Irritability
- ❑ Emotional problems
- ❑ Loss of balance
- ❑ Poor memory
- ❑ Dizziness
- ❑ Seizures/Epilepsy
- ❑ Concussion
- ❑ Lack of coordination
- ❑ Extremity numbness
- ❑ Extremity tingling
- ❑ Paralysis

Infections

- ❑ Strep throat
- ❑ Mononucleosis
- ❑ Tuberculosis
- ❑ Hepatitis
- ❑ HIV/AIDS

Urinary

- ❑ Frequent urination
- ❑ Urgency to urinate
- ❑ Incontinence
- ❑ Pain on urination
- ❑ Waking at night to urinate
- ❑ Urinary tract infection
- ❑ Blood in urine
- ❑ Kidney stones

Reproductive – Female

- ❑ Pregnant
- ❑ Hysterectomy
- ❑ PMS
- ❑ Uterine Fibroids
- ❑ STI
- ❑ Menstrual Pain
- ❑ Pelvic Pain

Reproductive – Male

- ❑ Testicular Pain
- ❑ STI

DECLARATION AND CONSENT TO TREATMENT

I, ______________________, consent to receive this treatment and understand that the sessions are for relaxation and stress reduction, relief of muscular tension, and to promote the healthy function of the body. I may stop the session at any time and will tell the therapist of any pain or discomfort that I feel during the session so that adjustments can be made and my comfort level can be found.

I further understand that the treatment should not be construed as a substitute for a medical examination, diagnosis or treatment and that I should see a physician or other qualified medical specialist for any physical or mental ailment that I am aware of.

I understand that the Registered Massage Therapist is not qualified to diagnose, prescribe or treat for any specific physical or mental illness, and that nothing said during the course of the treatment sessions should be construed as such. However, suggestions, recommendations and opinions may be expressed.

I attest that the information provided is true and accurate to the best of my knowledge.

I agree to pay my full account at the time of each visit or treatment.

If I am unable to make my appointment I must provide advance notification within 24 hours in which case no charge will be applied.

Patient's Full Name: ____
First Middle Last

Date of Consent: ______________________________
Day Month Year

____
Signature