ACTIVE APPROACH Health & Wellness Centre

# Massage 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 or reminder call)

Reminders: ☐ Text ☐ Phone Please provide us with your insurance card for a copy for our records

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 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:**

Twenty Four (24) 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: _____

**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.**

## 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 had massage therapy in the past? Yes No If Yes, when?: _____
- Have you received any other treatment for this condition? If yes, please describe and comment on its success _____

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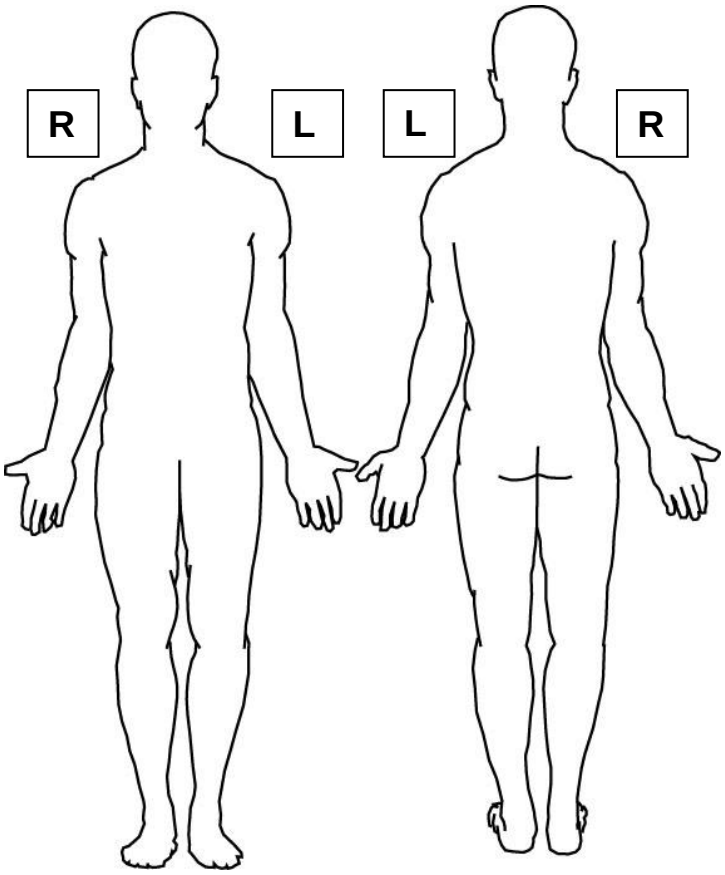
**Please use the following symbols on the diagrams below to illustrate your symptoms**

PAIN / / / / / / / RADIATING PAIN NUMBNESS + + + + + + +

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

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