South Hill Massage Therapy &
Broker's Active Care Klinic
Chiropractic, Massage, Acupuncture & Fitness Centre
3350 2nd Avenue West Prince Albert, SK S6V 5E9
(306) 922-7028 ph (306) 953-9841 fax

MASSAGE THERAPY INTAKE FORM
(Please read carefully)

Case History:

Name: ______________________________ **Date:** ______________________

Date of Birth: ____________________ **Hospitalization #:** ______________________

Address: ________________________**City:** ____________ **Postal Code:** ____________

Phone Numbers: Home: ______________________ **Cell:**______________________

Work:______________________

Occupation:______________________ **Email:** ______________________

Physician's Name: ____________________ **Chiropractor's Name:** ____________________

Referred By: ______________________

Have you previously had a massage treatment? Yes______ No______ **when?**__________________

Reason for today's massage therapy treatment:

____

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Are you under any medical supervision? Yes_______ No________
If Yes, for what reason?

____

Are you taking any medications? Yes_______ No________

If YES, what is it, and what is it for?

____

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Are you pregnant? Yes______ No______ **How many weeks?** ______________________

Are you seeking any help from other health care providers? Yes__________ No ____________
(example: physiotherapy 2x/wk, chiropractor 1x/mth)
If Yes, Please explain

____

____

Is there any other information you should disclose in order to have a successful treatment?

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Please Read the following carefully

Mark any of the following that you have presently or had in the past:

	Present	Past		Present	Past
Contagious Disease			Cancer		
Rheumatoid Arthritis			Tumors		
Phlebitis/Circulatory Problems			Kidney Disease		
High or Low Blood Presure			Skin Infections		
Pelvic Inflammatory Disease			Veneral Disease		
Osteoporosis			Crohn's Disease		
Heart Disease			IBS		
Diabetes			Colitis		

Mark any symptoms presently or recently experienced:

Cardiovascular	Present	Past	Women	Present	Past
Fever			Frequent Menstrual Cramps		
Shortness of Breath			Pelvic Inflammation / Infection		
Repeated Chest Pain					
Varicose Veins			Men	Present	Past
Dizziness / Fainting Spells			Prostrate / Urinary Infection		
Frequent cold feet/hands					
Unexpected muscular cramps			Nervous System	Present	Past
Frequent tingling of lips/fingers			Unexplained/sudden body weakness		
Bruising easily			Constant tight feeling in stomach		
			Constant tight feeling in throat		
Immune System	Present	Past			
Frequent Cough / Cold			Integumentary System	Present	Past
Frequent Mucal Congestion			Frequent Skin Infections		
Sinus Problems			Acne/Cysts		
Asthma			Profuse Sweating		
Frequent Sore Throats			Communicable Skin Infection		
Ear Aches/Infections			Psoriasis		
Frequently Fatigued			Eczema		
History of Swollen Glands					
Allergies			Musculoskeletal	Present	Past
			Painful Muscle Tension		
Psychiatric	Present	Past	Headache		
Anxiety			Muscle Cramps		
Depression			Sore Aching Joints		
Constant irritability			Repeated Ligament Sprains		
Excessive Fear			Repeated Tendon Strains		
Excessive Anger			Dislocation		
			Flat Feet		
Other	Present	Past	Painful/Difficulty Walking		
Swelling			Low Back Pain/Discomfort		
Stiffness			Mid Back Pain/Discomfort		
Limited Movement			Shoulder/Neck Pain/Discomfort		
Constipation / Diarrhea					

Initial this page when you have read it _______