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/Postal Code: _____

Phone Numbers: (H)_____

(W)_____

Occupation:_____

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:

_____

_____

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?

_____

_____

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?

_____

_____