Absolute
CHIROPRACTIC WELLNESS CENTRE

3774 Walker Road
Windsor, Ontario N8W 3S8
T: (519) 967-8592
F: (519) 967-8595

Massage Therapy Intake Form

An accurate health history is important to ensure that it is safe for you to receive a massage treatment. If your health status changes in the future, please let us know.

Name: _____ Date of birth: _____

Address: _____ Phone: _____

City/Postal Code: _____ Referred By: _____

Email (for appointment reminders): _____

Emergency Contact Name and Phone Number: _____

Occupation: _____ Primary Complaint: _____

_____

Do you have extended health care insurance? ☐ YES ☐ NO Name of Extended Health Care:_____

If answered YES please provide Policy #_____ ID # _____

Insured Member's Name: _____ and Date of Birth: _____

Please indicate conditions you are experiencing, or have experienced:

Respiratory
- ☐ Chronic cough
- ☐ Shortness of breath
- ☐ Bronchitis
- ☐ Asthma
- ☐ Emphysema

Cardiovascular
- ☐ High blood pressure
- ☐ Low blood pressure
- ☐ Congested heart failure
- ☐ Heart attack
- ☐ Phlebitis
- ☐ Stroke / CVA
- ☐ Pacemaker or similar device
- ☐ Heart disease

Other Conditions
- ☐ Loss of sensation
- ☐ Diabetes
- ☐ Allergies
- ☐ Epilepsy
- ☐ Thyroid
- ☐ Cancer_____

Head / Neck
- ☐ Vision problems
- ☐ Vision loss
- ☐ Ear problems
- ☐ Hearing loss

Infections
- ☐ Hepatitis
- ☐ HIV
- ☐ TB

Women
- ☐ Pregnant (due :_____)

Soft Tissue / Joint Discomfort / Pain
- ☐ Neck
- ☐ Low Back
- ☐ Mid Back
- ☐ Shoulders
- ☐ Arms
- ☐ Legs
- ☐ Knees
- ☐ other _____

Skin
- ☐ Skin conditions

_____

Other Medical Conditions:

_____

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Special Note: (Presence of internal pins, wires, artificial joints, special equipment, etc.)

_____

Current medications: _____

Surgery: _____ Date: _____

Primary care Physician: _____ Phone Number: _____

Are you receiving other health care (Physiotherapy, Chiropractic etc.)? ☐ YES ☐ NO

If Yes, Specify: _____

INFORMED CONSENT TO MASSAGE THERAPY TREATMENT

I understand that the massage therapist is providing massage therapy services within their scope of practice as defined by the Massage Therapist Association of Ontario, Canada.

I hereby consent for my therapist to treat me with massage therapy for the above noted purposes including such assessments, examinations and techniques, which may be recommended, by my therapist.

I acknowledge that the therapist is not a physician and does not diagnose illness or disease or any other physical or mental disorder. I clearly understand that massage therapy is not a substitute for a medical examination. It is recommended that I attend my personal physician for any ailments that I may be experiencing. I acknowledge that no assurance or guarantee has been provided to me as to the results of the treatment. I acknowledge that with any treatment there can be risks and those risks have been explained to me and I assume those risks.

I acknowledge and understand that the therapist must be fully aware of my existing medical conditions. I have completed my medical history form as provided by my therapist and disclosed to the therapist all of those medical conditions affecting me. It is my responsibility to keep the massage therapist updated on my medical history. The information I have provided is true and complete to the best of my knowledge.

I authorize my therapist to release or obtain information pertaining to my condition(s) and/or treatment to/from my other caregivers or third party payers.

I have read the above noted consent and I have had the opportunity to question the contents and my therapy. By signing this form, I confirm my consent to treatment and intend this consent to cover the treatment discussed with me and such additional treatment as proposed by my therapist from time to time, to deal with my physical condition and for which I have sought treatment. I understand that at any time I may withdraw my consent and treatment will be stopped.

Patient Name: _____ Signature of Patient/Guardian: _____

Please initial_____ to allow consent to submit online to my EHC. Date Signed: _____