

# New Patient Intake – Massage Therapy

Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Gender:  M  F  
Address: \_\_\_\_\_  
City: \_\_\_\_\_ Postal Code: \_\_\_\_\_  
Telephone Number: \_\_\_\_\_  
Health Card Number: \_\_\_\_\_  
Occupation: \_\_\_\_\_ Business Telephone: \_\_\_\_\_  
Check One:  Single  Married  Widowed  Divorced  Separated   
Partner's Name: \_\_\_\_\_  
Referred to our office by: \_\_\_\_\_

## Current Health Condition

Area of Main Problem: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

When did this condition begin? \_\_\_\_\_  
Is it getting  Better?  Worse?  Staying the Same?  Comes and Goes?  
Have you had this before?  Yes  No If Yes, When? \_\_\_\_\_  
Have you had treatment for this or previous episode?  Yes  No  
If Yes - Where? \_\_\_\_\_  
What aggravates your problem? \_\_\_\_\_  
What alleviates it? \_\_\_\_\_  
Is the problem  Constant?  Intermittent?

Your Medical Doctor's Name: \_\_\_\_\_

List any Medications or Vitamin Supplements you presently take: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Do you suffer from any condition other than that which you are now consulting us? \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

List any surgery, accidents and falls, including year: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_