Exercise & physical activity: ( ) **very** 5-7 X/week ( ) **moderate** 3-4 X/ week
( ) **light** 1-2 X/week ( ) **sporadic** ( ) **non-active**

Work, do you routinely ( )sit ( )stand ( ) light manual labour ( ) heavy labour ( )combination

Daily **water** consumption? ( ) light ( ) moderate ( ) heavy : **Caffeine?** ( ) light ( ) mod ( ) heavy

Do you **smoke?** ( ) light ( ) moderate ( ) heavy Do you consume **alcohol?** ( ) daily ( ) socially

Type of activities or hobbies?____

REASON FOR VISIT Therapy?_________Relaxation?_________

Please describe your present complaint and shade in areas of concern on the diagram.

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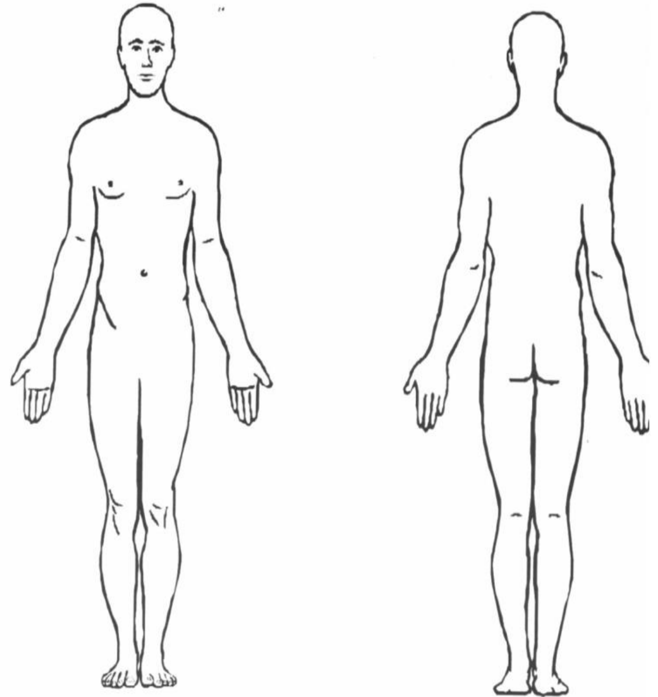

Initial onset of pain?_________________________

Is the pain ( )local ( )radiating ( ) throbbing ( ) dull
( ) stabbing ( ) pins & needles( ) numbness ( ) burning
( ) intermittent ( ) constant

Is the pain ( ) less ( ) worse later in the day or
( ) less ( ) worse on waking?

Have you had any serious injuries, accidents or falls in the past 5 years? **Y/N** Please explain _________

____

Have you had any surgeries in the past 3 years? **Y/N**
Please explain ______________________________

____

Have you ever had any fractures? Do you have any pins, plates, or joint replacements? or any other notes of caution_________________________________

Contraindications – upon assessment at your initial and/or subsequent appointments, there may be medical concerns, which may require you to see your doctor prior to a massage therapy treatment. You will not be billed for that massage appointment.

This is to acknowledge my wish to **consent** to receive massage therapy treatments as outlined to me. I understand that I may withdraw consent at anytime and that treatment will be stopped.

The information provided and documented by me on this form is true and accurate to the best of my knowledge.

______________________________________ ________________

Signature of patient Date

Reviewed and updated history intake form:

Date Patient signature MT Initials ____________________________