knead.
REGISTERED MASSAGE THERAPY

PHONE	(250) 753-6322
EMAIL	info@kneadtherapy.ca
CLINIC	975 Terminal Ave., Nanaimo BC

Date	month	day	year

INTAKE FORM • PATIENT INFORMATION

GENERAL DETAILS

First name	
Last name	
Personal health #	

Age		**Birthday**	mm/dd/yy
Gender	☐ Male ☐ Female ☐ _____		
How did you hear about us?			

CONTACT INFORMATION

Home address		
City & province		postal code
Home phone	area code	
Cell phone	area code	

Email address		
How may we remind you of appointments?	☐ Email ☐ Text ☐ Phone	
Emergency contact		
Emergency phone	area code	

OCCUPATION & INSURANCE DETAILS

Occupation		
Business or employer		
Work phone	area code	

May we contact you at work?	YES	NO
Is this treatment in regards to an ICBC claim?	YES	NO
Is this treatment in regards to a WCB claim?	YES	NO

Do you have extended health insurance?	YES	NO
Insurance provider		
Policy number		
Member ID number		
Coverage holder	☐ Self ☐ Spouse ☐ Parent	
Coverage holder's name (if spouse or parent)		
Coverage holder birthdate (if spouse or parent)	mm/dd/yy	

GENERAL PRACTITIONER INFORMATION

Name of GP			
Date of last visit to GP	month	day	year
Reason for last visit			

Are you seeing a medical specialist?	YES	NO
Name of specialist		
Reason for specialist		

HEALTH COMPLAINTS

Primary health complaint	
Other health complaints	
What would you like to gain from our visit? What are your two biggest health goals?	

MEDICAL HISTORY

Have you had previous care from:	☐ **Massage Therapist** ☐ **Chiropractor** ☐ **Naturopath** ☐ **Physiotherapist** ☐ **Acupuncturist**
Name of practitioner	
Date of last visit	month / day / year

Have you had any recent:	☐ **X-Rays** ☐ **CT Scans** ☐ **MRIs**
Name of practitioner	
Date of last visit	month / day / year

List any surgeries, hospitalizations, MVAs, or major accidents (please include date)	
List medications or supplements you are taking, and the reason for taking it	

What is your overall stress level?	
Reasons for stress?	

How often do you exercise?	
What types of exercise?	

Do you smoke?	YES	NO
How many per day?		
How long have you smoked for?		

FOR WOMEN ONLY			
Are you pregnant?	YES	NO	MAYBE
Do you have children?	YES		NO
If yes, by:	Natural Delivery		Caesarean Delivery

Pain and discomfort can be traced back to many different origins. To obtain a complete picture of your overall health, please complete this form. If you are having any difficulty with any of the following, please check (✔) the box.

GENERAL
- ☐ Insomnia
- ☐ Fatigue
- ☐ Weight loss
- ☐ Weight gain

HEAD
- ☐ Headache
- ☐ Dizziness
- ☐ Head trauma
- ☐ Fainting
- ☐ Blacking out

EYES
- ☐ Itching/redness
- ☐ Change in vision
- ☐ Cataracts
- ☐ Light sensitivity
- ☐ Flashes in vision
- ☐ Spots in vision
- ☐ Glaucoma

EARS
- ☐ Ringing/tinnitus
- ☐ Impaired hearing
- ☐ Earache
- ☐ Dizziness
- ☐ Discharge

MOUTH & THROAT
- ☐ Bleeding gums
- ☐ Cold sores
- ☐ Sore throat
- ☐ Jaw/TMJ problems
- ☐ Hoarseness
- ☐ Swollen glands
- ☐ Goiter

NOSE
- ☐ Hayfever
- ☐ Loss of smell
- ☐ Nosebleeds
- ☐ Sinus problems

LUNGS
- ☐ Difficulty breathing
- ☐ Shortness of breath
- ☐ Persistent cough
- ☐ Coughing phlegm
- ☐ Coughing blood
- ☐ Asthma
- ☐ Pneumonia
- ☐ Emphysema
- ☐ Bronchitis
- ☐ Infections

VASCULAR
- ☐ Angina
- ☐ Murmurs
- ☐ Heart disease
- ☐ Chest pain
- ☐ Palpitations
- ☐ Ankle swelling
- ☐ Cold feet/hands
- ☐ Leg cramps
- ☐ Calf pain
- ☐ Varicose veins
- ☐ Low blood pressure
- ☐ High blood pressure

GASTROINTESTINAL
- ☐ Bloating/gas
- ☐ Heartburn
- ☐ Ulcers
- ☐ Liver disease
- ☐ Gall bladder disease
- ☐ Vomiting/nausea
- ☐ Abdominal pain
- ☐ Diarrhea
- ☐ Constipation
- ☐ Blood in stool
- ☐ Hemorrhoids
- ☐ Hernias

URINARY
- ☐ Difficulty urinating
- ☐ Pain urinating
- ☐ Blood in urine
- ☐ Incontinence
- ☐ Bed-wetting
- ☐ Urinary urgency
- ☐ Frequent urination
- ☐ Frequent infections
- ☐ Kidney stones

NEUROLOGICAL
- ☐ Seizures/epilepsy
- ☐ Strokes
- ☐ Tingling sensation
- ☐ Numbness
- ☐ Muscle weakness
- ☐ Difficulty walking
- ☐ Poor coordination
- ☐ Paralysis
- ☐ Speech problems
- ☐ Loss of memory

MUSCLE & BONE
- ☐ Joint pain
- ☐ Swollen joints
- ☐ Stiffness
- ☐ Muscle ache
- ☐ Foot trouble
- ☐ Arthritis
- ☐ Bone pain
- ☐ Fractures
- ☐ Dislocations

SKIN
- ☐ Rash
- ☐ Itching/hives
- ☐ Changes in moles
- ☐ Acne
- ☐ Psoriasis
- ☐ Eczema

ENDOCRINE
- ☐ Diabetes
- ☐ Hypoglycaemia
- ☐ Hormone therapy
- ☐ Thyroid problems
- ☐ Heat/cold intolerance
- ☐ Excessive thirst
- ☐ Excessive hunger
- ☐ Excessive sweating
- ☐ Night sweats

EMOTIONAL
- ☐ Depression
- ☐ Mood swings
- ☐ Anxiety/nervousness
- ☐ Tension
- ☐ Phobias
- ☐ Alcohol/drug abuse

CONDITIONS
- ☐ AIDS/HIV
- ☐ Eating disorders
- ☐ Heart condition
- ☐ Rheumatic arthritis
- ☐ Rheumatic fever
- ☐ Alcoholism
- ☐ Cancer/tumor
- ☐ Polio
- ☐ Parkinson's
- ☐ Multiple sclerosis
- ☐ Gout
- ☐ Anemia
- ☐ Osteoporosis
- ☐ Osteoarthritis
- ☐ High cholesterol
- ☐ Fibromyalgia
- ☐ Chronic fatigue
- ☐ Hepatitis
- ☐ Migraines
- ☐ Contagious blood diseases

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INTAKE FORM • CONSENT FORM

Please read the following carefully and enquire if you have any questions or concerns.

I hereby request and consent to the performance of massage therapy and/or other soft tissue procedures, including various forms of massage therapy, hydrotherapy, range of motion, and orthopedic testing by the Registered Massage Therapist listed below. I have had the opportunity to discuss the nature and purpose of massage therapy with the practitioner. I have disclosed all medical conditions, mental and emotional, for which I am receiving treatment currently or have received treatment in the past.

I understand that results are not guaranteed.

I further understand and am informed that in the practice of massage therapy, as in all health care, there are some very slight risks to treatment, including but not limited to muscle tenderness, stiffness, and sometimes slight bruising. I do not expect the RMT to be able to anticipate and explain all the risks and complications associated with soft tissue manipulations. I wish to rely on the practitioner to exercise judgment during the course of my treatment(s), to apply those treatments which he/she feels at the time, based on the facts known, are in my best interest.

I have read the above statements carefully and have had the opportunity to ask questions about their concerns.
By signing below I am signifying agreement to the above-mentioned massage therapy procedures, and I intend this consent to apply to and cover the entire course of treatment(s) for my present condition. I understand that I can and may change my mind to consent at any time during treatment, and that treatment will be stopped as requested.

I authorize any information I have provided to be shared with any practitioner working within Knead Therapy, and also with my expressed consent, to be shared with my Medical Doctor if required.

CANCELLATION FEE DISCLAIMER

Please note that we require a minimum of 24 hours notice for any cancellations or changes or you may incur a penalty. A fee will be charged for all missed appointments.	patient initial

ELECTRONIC BILLING CONSENT

I consent to Knead Therapy electronically billing on my behalf, if my benefits will allow, and agree to pay any balance owing.	patient initial

Patient Signature				**Therapist Signature**			
Patient Name (please print)				**Therapist Name** (please print)			
Date Signed	month	day	year	**Date Signed**	month	day	year