MICRO
MASSAGE & WELLNESS

CONFIDENTIAL PATIENT INTAKE FORM

Name _____ **Birthdate** _____
MM/DD/YYY

Address _____ **Family Doctor** _____

_____ Phone _____

Phone Home_____ **Emergency Contact:**
(Name, Relationship) _____

Cell _____ Phone _____

Email _____ Reminder: Text or **Email** or Phone Call or NO reminder (Circle)

Occupation _____ Health Insurance Provider _____

Care Card # _____ Member ID# _____

Policy # _____

ICBC or WCB? (Circle if App.) Claim #_____

How did you hear about us?_____

Medical History

Are you pregnant? If so, how far along are you?: (Please CIRCLE) Yes | No

_____

Please list any Medications or on-prescription vitamins you presently taking:

_____

Known Allergies (including medications, foods, seasonal, oils and lotions, etc.)

_____

Do you have any family history of medical conditions? Please list,

_____

Have you ever been hospitalized, had any major accidents, illnesses, or surgeries? Please Comment:

_____

Intake Continued…

Are you receiving or have you received other therapy / treatment such as, Massage therapy, Chiropractor, Physiotherapy, Naturopath, Acupuncture or Other (Please specify): `

_____

Please indicate conditions you are you are experiencing presently with a check OR circle conditions you have experienced in the past.

Skin:

- ☐ Rash
- ☐ Psoriasis
- ☐ Eczema
- ☐ Other: _____

Muscular/Joints

- ☐ Weakness or loss of strength
- ☐ Osteoporosis/ Osteopenia
- ☐ Rheumatoid Arthritis
- ☐ Sprain/Strain
- ☐ Osteoarthritis
- ☐ Tendonitis
- ☐ Other _____

Respiratory

- ☐ Asthma
- ☐ Bronchitis
- ☐ Difficulty breathing
- ☐ Emphysema
- ☐ Smoking
- ☐ Other _____

Cardiovasular

- ☐ High/Low Blood Pressure
- ☐ Heart attack
- ☐ Stroke
- ☐ Poor circulation
- ☐ Other _____

Head / Neck

- ☐ Headaches
- ☐ Post-concussion
- ☐ Sinus problems
- ☐ Visual impairment
- ☐ Hearing impairment
- ☐ Speech impairment
- ☐ Migraines
- ☐ Concussion
- ☐ Jaw pain (TMJD)
- ☐ Other _____

GI Tract

- ☐ Gas
- ☐ Constipation/ Diarrhea
- ☐ Painful elimination
- ☐ Other _____

Mental Health

- ☐ Depression
- ☐ Anxiety
- ☐ PTSD
- ☐ Dementia
- ☐ Other _____

Other

- ☐ Diabetes
- ☐ Fever
- ☐ Numbness/ tingling
- ☐ Liver/ Kindey/ Bladder conditions
- ☐ Cancer
- ☐ Insomina
- ☐ Fainting
- ☐ Stress
- ☐ Other _____

Current Condition

Please CIRCLE the answer closest to how you PRESENTLY feel:(1=poor,2=average,3=good,4=very good,5 = excellent)

Quality of Sleep	1	2	3	4	5	Hours of sleep per night (approx.)	_____
Energy Level	1	2	3	4	5	Numbers of meals you regularly eat per day	_____
Eating Habits	1	2	3	4	5	Numbers of days you exercise	_____

Intake Continued…

Current Condition continued…

List Activities(Hobbies, Sports, etc.)_____

Smoker or Non-smoker (CICRLE one)

Please describe your current condition & symptoms:

_____

_____

How long have you had this condition?

_____

How did it start?

_____

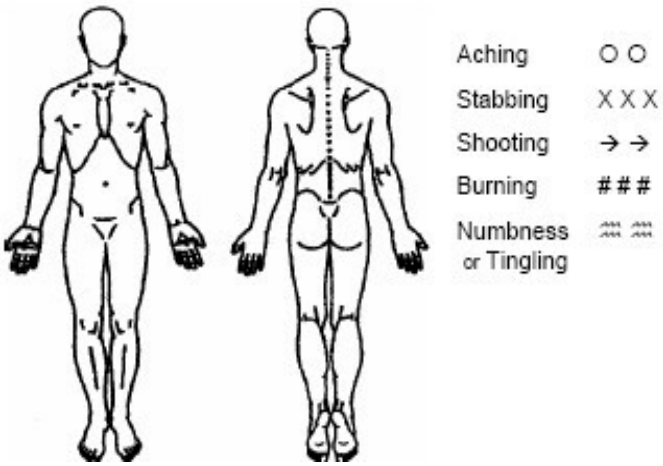
What aggravates it?

_____

What relieves it?

_____

Please indicate on the diagram the nature of your symptoms, using the symbols indicated:



Cancellation Policy

The Registered Massage Therapists at MICRO Massage & Wellness Clinic make every effort to ensure your treatment is safe and effective. The approach to treatment may vary depending on your condition(s). At any time before or during the massage treatment, you have the right to ask that the treatment, or portion of, be discontinued. If you have any questions or concerns related to the treatment or techniques used, we encourage you to communicate this to your therapist.

This case history form will be kept as a part of your patient file. Files will only be permitted amongst other Practitioners in order to provide patient centered care.

The Therapist at this clinic run their own practices and receive their sole source of income from the treatments they provide for you. Your appointment time has been reserved especially for you. In courtesy to your therapists and fellow patients, we require that you provide us with twenty-four (24) hours notice of any cancellation or change of appointment time. In the absence of 24 hour notice, you will be charged the full cost of your treatment, unless we are able to fill your appointment with another patient, in which case, you will not be charged. You will be required to pay for any treatment related fees which have not been or are not covered by your health insurance.

"I authorize MICRO Massage & Wellness and its associated Practitioners to collect my personal and medical information as documented above in order to contact me and give permission for the clinic to leave messages regarding appointments at any of the contact information I have provided. I also understand that my personal and medical information is confidential and will only be disclosed to third parties with my permission. I have read and understood the above and that the information proved in this case history form is correct to my knowledge. I accept the conditions listed above outlining MICRO Massage & Wellness cancellation policy and I give full consent for treatment."

Signature of Patient_____Date:_____

Signature of Patients Legal-Guardian_____ Date:_____