

Integrative Health Institute

46 Sherbourne St. 2<sup>nd</sup> Floor  
Toronto, ON M5A2P7  
P: 416.260.6038  
F: 416.260.9799

Massage therapy intake Form

Please complete the following form in order to provide us with the background information we require to ensure you receive comprehensive care. All information will be kept confidential.

Contact Information:

Name	_____	Emergency Contact	_____
Gender (circle)	Male      Female	Contact Relationship	_____
Date of Birth	_____	Emergency Contact #	(    )
E-mail Address	_____	Medical Doctor	_____
Home Phone #	(    )	Medical Doctor #	(    )
Cell	(    )	Medical Doctor Address	_____
Home Address	_____	Medical Doctor Email	_____
		YES   NO	Can we send you our seasonal newsletter and monthly calendar of events via email. Your email address will not be shared.
Occupation	_____	YES   NO	Do you have a known allergy to coconut oil?
Employer	_____		How did you hear about the Integrative Health Institute? (If another person, please provide name)
Work Phone #	(    )		_____

Health Priorities / Chief Concerns:

List your main health concerns (or reasons for visiting the clinic) in order of importance

1. \_\_\_\_\_
2. \_\_\_\_\_
3. \_\_\_\_\_

Medical History:

How would you describe your general state of health? (circle one)    excellent    good    fair    poor

Have you received massage therapy before?    Yes    No

Did a health care practitioner refer you for massage therapy?    Yes    No

If yes, please provide their name and contact information \_\_\_\_\_

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**Medical conditions:** Please indicate any conditions you are experience or have experienced

Medical Condition/ Hospitalization	Symptoms	Date of Diagnosis/ Diagnosed By	Is Condition still Present / Description
Cardiovascular	High Blood Pressure, Low Blood Pressure, Congestive Heart Failure, Heart Attack, Phlebitis / Varicose Veins, Stroke / CVA, Pacemaker, Heart Disease		
Respiratory	Chronic Cough, Shortness of Breath, Bronchitis, Asthma, Emphysema		
Infections	Hepatitis, TB, HIV, Herpes		
Physical Conditions	Injuries, Surgical Implants, Osteoporosis		
Other Conditions	Loss of Sensation, Diabetes, Epilepsy, Cancer, Skin Conditions, Arthritis, Surgery, Digestive Conditions, Hemophilia, Mental Illness		
Head / Neck	Headaches, Migraines, Vision Problems, Vision Loss, Ear Problems, Hearing Loss		
Allergies	Allergies and/or Food Sensitivities		
Women's Health	Pregnancy (due date: _____), Gynecological Conditions		

**Medications/Supplements:** Please list all current medications/supplements

Medication/Supplement	Dose / Length of Use	Prescribing Health Professional	Condition it is treating

**Additional Information:** Please indicate where you are feeling pain

