INTAKE FORM

Business Name: _____

Address: _____

_____

First Name _____ Date of birth _____

Referred by _____

Email Address _____ Mobile Phone # _____

Home Phone # _____ Work Phone # _____

Street Address City _____

State/Province _____ Zip Code _____

Emergency contact name _____ Physician's name _____

Emergency contact relationship Physician's phone # _____

Emergency phone # _____

Date of initial visit _____

How would you rate your general health?

- ◯ Excellent Good
- ◯ FairPoor

Have you had a professional massage before?

- ◯ **Yes *(Date of last treatment)*** _____
- ◯ No

List current medications & the conditions they are treating:

List any major accidents or surgeries (including dates):

INTAKE FORM

Please tell us about any allergies or hypersensitivities:

Reason for initial visit:

HEAD NECK

- ◯ Headaches/migraines
- ◯ Vertigo / dizziness
- ◯ Ringing in ears
- ◯ Hearing loss
- ◯ Vision problems
- ◯ Vision loss

RESPIRATORY

- ◯ Asthma
- ◯ Shortness of breath
- ◯ Chronic cough
- ◯ Bronchitis
- ◯ Emphysema
- ◯ Sinusitis
- ◯ Frequent colds
- ◯ Smoker
- ◯ Family history of respiratory difficulties

NERVOUS SYSTEM

- ◯ Sensory loss/change
- ◯ Numbness/tingling
- ◯ Sciatica
- ◯ Epilepsy
- ◯ Seizures
- ◯ Multiple sclerosis

MUSCULOSKELETAL SYSTEM

- ◯ Arthritis
- ◯ Family history of arthritis
- ◯ Osteoporosis
- ◯ Tendonitis
- ◯ Bursitis
- ◯ Jaw pain (TMJ)
- ◯ Pins/Plates/Wires/Artificial joint

REPRODUCTIVE

- ◯ Pregnant
- ◯ Given birth
- ◯ Gynaecological problems

CARDIOVASCULAR

- ◯ High blood pressure
- ◯ Low blood pressure
- ◯ Heart attack
- ◯ Stroke
- ◯ Heart disease
- ◯ Poor circulation
- ◯ Phlebitis/Varicose Veins
- ◯ Pacemaker
- ◯ Haemophilia
- ◯ Chronic congestive heart failure
- ◯ Family history of cardiovascular problems

SKIN & INFECTIONS

- ◯ Hepatitis
- ◯ HIV / AIDS
- ◯ Herpes
- ◯ Tuberculosis
- ◯ Lyme disease
- ◯ Infectious skin conditions

OTHER CONDITIONS

- ◯ Cancer
- ◯ Diabetes
- ◯ Unexplained weight loss
- ◯ Digestive conditions
- ◯ Fibromyalgia
- ◯ Chronic fatigue syndrome
- ◯ Depression
- ◯ Anxiety
- ◯ Psychiatric disorder
- ◯ Other conditions

CONSENT FORM

Business Name: _____

Address: _____

_____

It is my choice to receive treatment. I am aware of the benefits and risks and give my consent for treatment.

I understand that there is no implied or stated guarantee of success of the effectiveness of individual techniques or series of appointments. I acknowledge that this treatment is not a substitute for medical care, medical examination, or diagnosis.

I have stated all medical conditions that I am aware of and will inform my practitioner of any changes in my health status.

I understand that my personal health information will be collected. I understand that all information that I provide will be kept confidential unless required by law. I understand and consent that my medical information may be shared by the various care providers involved in my care and treatment.

Treatments may be covered by extended health care plans. I understand that it is my responsibility to confirm the exact details of my coverage.

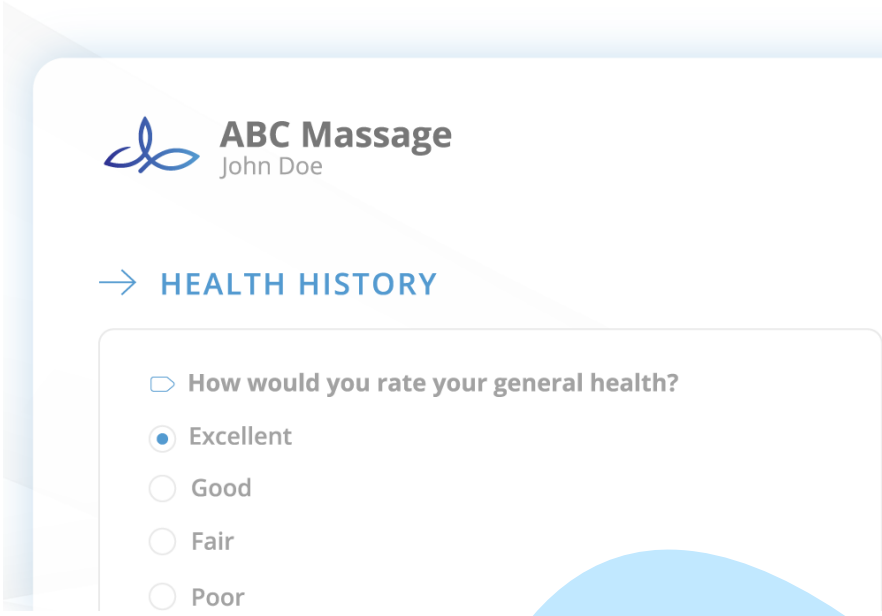
Name: _____

Signature: _____ Date: _____

Ready to try customizable online intake forms?

If you're just getting started, you may not think you need clinic management software yet. However, as your business grows, you'll need a system to keep things organized. It's a lot easier to start a business with good systems in place, than it is to try to incorporate them later.

At ClinicSense, we offer customizable and HIPAA and PIPEDA - compliant patient and client intake forms, so you can spend less time on paperwork, and more time with your clients.



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