Intrinsic Massage Therapy	433 St. Anne's Rd Winnipeg, MB R2M 3C7 Phone: 204-233-3935

PATIENT HISTORY

Date:_____ **Birth Date**: _____
Month / Day / Year

Patients Name: _____
First Last

Address: _____

City _____ Province _____ Postal Code _____

Phone: _____ / _____ / _____
Home Work Cellular

E-mail address: _____

How did you hear of our clinic? Yellow Pages: _____ Referral: _____
If yes, by whom were you referred by: _____

Medical Doctor: _____
Employer: _____ Occupation: _____
Address: _____
City Prov. Postal Code

What are your reasons for treatment?_____

Please check if your **currently** receiving treatment from any of the following:

_____ Medical Doctor _____Naturopath _____ Chiropractor_____Physiotherapist _____ Other

Have you **previously** received Massage Therapy? Yes: _____ No:_____
If **yes**, this Clinic ? _____ Other:_____

Have you ever had a **major** Surgery, Illness, or Accident? Yes: _____ No:_____
If yes, what? _____

Are you **currently** taking any medications? Yes: _____ No:_____

If yes, what type, and for what condition:_____

Do you smoke? Yes: ____ No:____ If yes, how many per day?
Do you drink? Yes: ____ No:____ If yes, how many drinks per week:
How would you rate the amount of stress you are subject to?_____

Please indicate on a scale of **1 to 10**, the extent to which you are currently satisfied with the following things: (**10** represents total **satisfaction**, **1** represents little or **no satisfaction**)

Physical Health & Fitness_____ **Mental & Emotional Happiness**_____
Energy _____ **Diet**_____ **Ability to Relax** _____

Please check, if you have, or had, to your knowledge, any of the following:

Conditions	Present	Past	Conditions	Present	Past
Arthritis			Epilepsy		
Communal Disease			High Blood Pressure		
Specify:			Hemophilia		
Cancer			Kidney Disease		
Cardiovascular Disease			Rheumatism		
Diabetes			Other:		

✓ **Check any of the following conditions currently bothering you:**

S = Slight M = Moderate I = Intense

	S	M	I		S	M	I
Painful Muscle Tension				Digestive Problems			
Muscular Cramps				Stomach/Intestinal Ulcers			
Sore Aching Joints				Abdominal Cramps			
Frequent Cracking or Popping Sounds in Joints				Painful Bowel Movements			
Ligament Sprain				Menstrual Problems			
Muscle Strain				Pelvic Inflammation			
Joint Dislocation				Urinary Infection			
Pain on Walking				Prostate Infection			
Flat Feet				Frequent Colds or Flu			
Sore Feet				Allergies			
Painful Legs				Asthma			
Painful Arms Pain				Low Blood Pressure			
Low Back				Frequent Cold Hand/Feet			
Mid-Back Pain				Bruise Easily			
Upper Back/Shoulder Pain				Varicose Veins			
Neck pain				Anxiety			
Headache				Depression			
Skin Infection				Constant Irritability			
Psoriasis				Unexplained or Sudden Weakness			
Eczema				Any other Conditions not listed?			

In case of emergency who can we contact? Please list two (2) people with their available phone numbers.

1)_____ 2)_____

Please note: there is a charge of Half price for any missed scheduled massage treatments without providing 24 Hour notice to our office. There is a $15.00 charge for any NSF or returned cheques, and the fee from our Banking institution. You will be sent an invoice for these Charges, and you will have 15 days to pay your outstanding balance.

The information contained on this form is true to the best of my knowledge. Intrinsic Massage Therapy will be the sole trustee of your file and all personal information within, as per the guidelines in The Personal Information Protection Act (abbreviated PIPEDA or PIPED Act).

_____ _____

Signature **Date**

I give my permission that my therapist may obtain and submit reports regarding my condition to/from my Physician, Chiropractor, Physiotherapist, Podiatrist, and/or, Attorney as required.

_____ _____

Signature **Date**