

WHOLSOME WELLNESS

MESSAGE INTAKE FORM

www.wholesomewell.com

(403) 615-8275

PERSONAL DATA

Name: _____ Date of birth (dd/mo/yyyy) _____

Address: _____ City, Province: _____

Postal Code: _____ Home Phone: _____ Cell Phone: _____

Email: _____

Occupation: _____ Referred By: _____

Emergency Contact: _____

Relationship: _____ Phone: _____

Have you used other complementary therapies in the past (i.e. acupressure, acupuncture, etc...)? Please list:

CLINICAL DATA

Gender: _____ Height: _____ Weight: _____

Present injury/problem: _____

Started when? _____

What action aggravates/recreates the pain? _____

What eases the pain? _____

Does pain radiate (felt away from source)? Y / N where? _____

Any stiffness/pain as result: _____

Past injuries/accidents/surgeries? _____

When? _____

Comments/details: _____

HEALTH HISTORY

Circle all that apply (mark '**P**' for **past** or '**C**' for **current** beside any that apply):

Asthma	Arthritis	Allergies (indicate: _____)	Blood clots	Bone injuries/ disease
Cancer/Tumors	Contact Lenses	Chronic Fatigue	Circulatory Problems	Depression
Dentures	Digestive Problems	Diabetes	Epilepsy	Fibromyalgia
Fracture	Hearing problems	Headaches / Migraines	Heart Attack	Heart Disease
Hernia	High Blood Pressure	Infectious Disease	Low Blood Pressure	Motor Vehicle Acc.
Muscle / Joint Pain	Muscle / Joint Stiffness	Numbness / Tingling	Phlebitis	Paralysis
Pregnancy (women)	Rash /Athlete's Foot	Seizures	Skin Disorders	Stroke
Surgery	TMJ Disorder	Vision Problems	Varicose Veins	Other: _____

Circle any that you experience **once or twice per week**:

Alcohol (# per day ___)	Allergies	Cold hands and feet	Constipation	Caffeine (#per day___)
Excessive urination	Fainting/Dizziness	Fatigue	Grinding of teeth	Headache
Heart or chest pain	Heavy limbs	Indigestion	Insomnia	Lower back pain
Loose bowel movements	Nervousness	Poor appetite	Smoking (#per day___)	Sore muscles
Tightness of jaw	Weakness	Other: _____		

Comments/details: _____

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MASSAGE INTAKE FORM

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MEDICATIONS / VITAMINS / SUPPLEMENTS / HERBS

Name:

Dosage/day:

Reasons for taking:

_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

On the image below please indicate, according to the legend, areas where you experience pain, numbness or tightness and areas where you may be ticklish.

Legend

*** = pain
NNN = numbness
XXX = tightness
TTT = ticklish

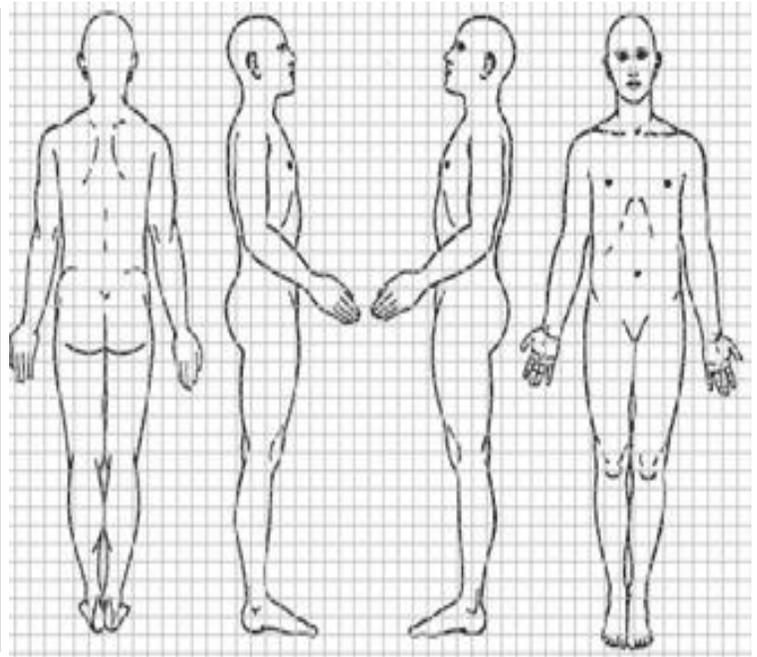
How would you describe the pain:

For areas of pain please indicate your pain level on a scale from one to ten (ten being the worst):

Area of pain:
Scale:

Patient Pain

_____	_____ out of 10
_____	_____ out of 10
_____	_____ out of 10



Waiver and Consent Form:

I, _____ (type name), release the massage practitioner from any and all liability from problems arising from the treatment as a result of information not given, or incorrectly given in this patient history.

I further understand that the massage should not be construed as a substitute for medical examination, diagnosis or treatment and that I should see a physician, chiropractor or other qualified medical specialist for physical or mental ailment that I am aware of.

Because massage is contraindicated under certain conditions, I affirm that I have stated my known medical conditions and answered all questions honestly. I agree to keep the therapist updated as to any changes in my medical profile and understand there is no liability on the therapist's part should I forget to do so.

Because my personal and medical information is confidential, I understand that this information will be seen only by the therapist, unless I give my consent in writing.

Client Signature: _____ Date: _____