Grande Prairie Therapeutic Massage

CLIENT INTAKE FORM

CONFIDENTAL INFORMATION

NAME:_____ DATE OF BIRTH:_____

ADDRESS:_____ CITY/PROVINCE:_____

POSTAL CODE:_____ CONTACT NUMBERS: (H)_____(C)_____

Do you have any of the following medical conditions? Please check all that are relevant.

( ) Asthma ( ) Diabetes ( ) Varicose Veins ( ) Epilepsy ( ) Skin Trouble ( ) High blood Pressure ( ) Low Blood Pressure ( ) Heart Disease ( ) Arteriosclerosis ( ) Arthritis ( ) Dizziness ( ) Pins or Pacemaker ( ) HIV/Aids ( ) Are you pregnant? ( ) Headaches ( ) Hernia ( ) Cancer ( ) Multiple Sclerosis ( ) Phlebitis ( ) Blood clots

Please list any medical conditions that were not stated above along with any allergies, joint or mobility problems or related surgeries and accidents along with their dates of occurrences.

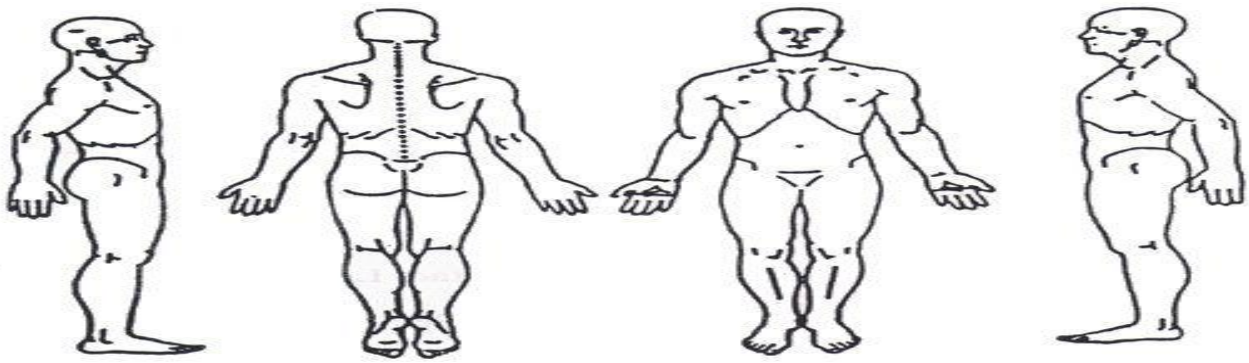
_____
_____
_____
_____

Please List any medications/vitamins you take regularly and what they are taken for:

_____
_____

What are your goals regarding the outcome of this massage? ( ) Pain relief ( ) General Relaxation and feeling of wellbeing ( ) Preventative for sports ( ) Rehabilitation from injury ( ) Other_____

Please mark on this diagram where you are experiencing any pain, numbness and tingling.



I affirm that I have listed all my known physical conditions and have answered all questions honestly. I agree to keep my practitioner updated with any changes to my medical profile. I understand that it is not a massage therapist's scope of practice to diagnose, prescribe or perform any spinal adjustments.

Your Signature:_____ Date_____