



Please fill out the following intake form as detailed as possible it will help to ensure safe and appropriate treatment. The following information is strictly confidential. The release of any information will only be granted with authorization from the pertaining client.

No show appointments and last minute cancellations will result in full treatment price owing Out of respect for clients being treated after you, treatment time will not be extended beyond your scheduled time. Your punctuality is appreciated.

Name: _____ Today's Date _____ Date of Birth: _____

Address: _____ Postal Code: _____ - _____

Occupation _____ Phone #'s- Cell:(____) _____ Home:(____) _____ Work:(____) _____

Describe Condition(s) you would like focused On:

Current Medical conditions: _____

Previous Medical conditions- _____

Trauma/Accidents (please specify dates) _____

Surgery: (Please specify dates) _____

Medications/Vitamins/Herbs _____

Please ✓ Current or Previous Conditions

General Health:

- Depression Irritability Anxiety Diagnosed Mental Illness
- HIV/AIDS Blood Thinning Meds Fatigue Epilepsy
- Hepatitis Diabetes Bleeding Disorders Cancer Night sweats
- Alcohol Addiction Issues Sleep- Trouble falling asleep Trouble staying asleep trouble waking in morning

Other/Details: _____

Musculoskeletal:

- Shoulder Pain Back Pain Pins & Needles Osteoporosis Repetitive strain/overuse
- Shoulder Tension Back Tension Numbness Where: _____ Where: _____
- Neck Pain ↑ Where on your Back? Ligament/ Tendon Injury Swelling/Edema Arthritis
- Upper back Where: _____ Which areas: _____
- Neck Tension Mid back Herniated Disk _____
- Hip problems Low back Injuries/Fractures _____
- Leg/ foot /ankle problems Arm/wrist/foot problems

Other/Details: _____

Cardiovascular:

High Blood Pressure Dizziness Stroke Cold Areas of Body:
Low Blood Pressure Blood Clots Varicose Veins _____
Heart Attack Irregular Heartbeat Pace Maker Other: _____
Fainting Palpitations Chest Pain/Discomfort _____

Respiratory:

Smoker Pneumonia Asthma Phlegm in Lungs Shortness of Breath Emphysema
Environmental Allergies Cough Bronchitis
Other/Details: _____

Reproduction/Genito-Urinary:

How long does you _____ How often does you _____ Fibroids/Cysts/Endometiosis PMS Symptoms
Period last? _____ Period come? _____ Irregular Periods Painful Periods
Flow: Heavy Moderate: Light: Menopause Hormone Issues (replacement,
Diseases etc)
Erectile Dysfunction Ejaculatory Dysfunction Prostate Problems Urination Problems
Kidney Stones
Other/ Details: _____

Digestion:

Diarrhea Gas Acid Reflux Eating Disorder Appetite: excessive lack of
Nausea/ Vomiting Belching Gallbladder/Liver probs. Bloating Constipation
Tired after meals Bad Breath Dry Mouth at Night
Other/Details: _____

Head, Eyes Nose and Throat:

Thyroid condition Eye Problems Sore throat Concussion Migraines Headaches where & when _____
Enlarged Glands Facial Pain Jaw tension Sinus Congestion Hearing Loss Ear Ringing Ear aches
Other/Details: _____

I have stated all my previous and current medical conditions and realize it is vital for proper treatment. I will keep my practioner updated on any changes in my health condition. I understand that I may stop the treatment at any time. I understand the benefits and risks of the treatment I will receive and am giving my informed consent to treatment. The therapist assumes full responsibility for the treatment. I agree to indemnify **Toronto Corporate Massage** against all liability, loss or claim arising from damage or injury to any person or property caused by or sustained in connection with **Therapist's** performance

Signature: _____ Date: _____