Core Kneads Therapeutics & Wellness RMT Patient Intake and Health History

To determine how to treat you safely and effectively, please complete the following to the best of your knowledge. If you have any questions, please ask. The details provided will be kept confidential unless required by law or you have given written permission to release the below information.

Name: _____ Date: _____

Address: _____ City: _____

Postal Code: _____ Province: _____ Date of Birth: _____

Phone: _____ Cell: _____ E-Mail: _____

Occupation: _____

Physician: _____ Phone: _____ Address: _____

Emergency Contact: _____ Phone: _____ Relationship: _____

How did you hear about this clinic? _____

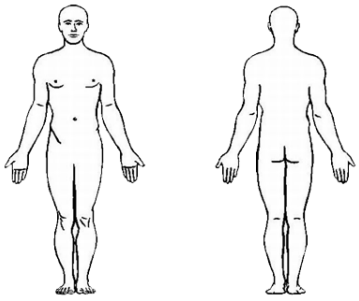
Were you referred by a Physician? _____ If so, who? _____

Have you ever received Massage Therapy? ___ If so, for what? _____

Are you being treated by any other Health Care Practitioner?

- □ Physician
- □ Massage Therapist
- □ Chiropractor
- □ Physiotherapist
- □ Naturopathic Doctor
- □ Acupuncturist
- □ Nutritionist/Dietician
- □ Other: _____

If so, for what/how often? _____



On the diagram, please circle any areas you experience symptoms (abnormal sensation, pain, tension, injury) and explain the discomfort:

_____

_____

_____

Please list all previous injuries, accidents, surgeries and dates of occurrence:

_____

_____

Please list all medications you are currently taking: _____

_____

_____

Please indicate which of the following conditions you have or are currently experiencing:

Cardiovascular	Respiratory	Digestive
□ High blood pressure (hypertension)	□ Bronchitis	□ Crohn's disease
□ Low blood pressure (hypotension)	□ Chronic cough	□ Irritable bowel syndrome (IBS)
□ Heart disease	□ Shortness of breath	□ Ulcerative colitis
□ Chronic congestive heart failure	□ Asthma	□ Ulcers
□ Heart attack	□ Emphysema	□ Constipation
□ Phlebitis/Varicose veins	□ Sinusitis	□ Gall stones
□ Stroke	□ Strep throat/Mono	□ Liver disease
□ Bruise easily		
□ Pacemaker (or similar device)	□ Other: _____	□ Other: _____
□ Other: _____	_____	_____
Nervous	**Skin**	**Head/Neck**
□ Altered sensation	□ Fungal infection (i.e., athlete's foot)	□ Headaches
□ Nerve lesion	□ Plantar warts	□ Migraines
□ Carpal tunnel	□ Psoriasis	□ Vision problems/loss
□ Sciatica	□ Eczema	□ Ear problems/hearing loss
□ Seizures/Epilepsy	□ Herpes simplex	□ Dizziness
□ Parkinson's		
□ Multiple Sclerosis	□ Other: _____	□ Other: _____
□ Cerebral Palsy	_____	_____
□ Other: _____		
Muscles/Joints	**Other**	**Women**
□ Fibromyalgia	□ Diabetes	□ Pregnant
□ Osteoporosis	Type: _____	Due date: _____
□ Disc herniation	□ Hepatitis	□ Menstruation disorders
□ Degenerative disc disease (DDD)	□ HIV/AIDS	□ Hysterectomy
□ Arthritis	□ Chronic fatigue syndrome	□ Endometriosis
Specify type and location:	□ Environmental illness	□ Painful menstruation
_____	□ Haemophilia	□ Menopausal problems
_____	□ Allergies	□ Caesarean section
□ Pain/Stiffness	Specify: _____	□ Other: _____
○ Head	_____	
○ Neck	□ Tumours/Cysts	
○ Jaw	□ Cancer	
○ Back	□ Mental illness	
○ Arms/Hands	□ Other: _____	
○ Legs/Feet	_____	
□ Other: _____	_____	
_____		

By my signature below, I authorize that the above information is correct to the best of my knowledge. I am also aware of Core Kneads' **cancellation policy**, and will provide 24 hours notice if I cannot keep my scheduled appointment. If I fail to give sufficient notice, I acknowledge that I may be charged a fee that cannot be billed through my insurance provider.

_____ _____

(Patient Signature) (Date)

x: _____ _____

(Update)

x: _____ _____

(Update)