INTERNAL USE ONLY	
Client No:	
Next update:	

CLIENT INTAKE

By providing the information requested below, you will assist us in treating you in a safe and efficient manner. Questions allowed or required by law. Your written permission will be required prior to release of any information to a third party.

Name: _____ Date of Birth (d/m/y): _____

Address: _____
No. Street Apt City Province Postal Code

Primary phone: ○ Home ○ Work ○ Mobile: _____ Confidential: ○ Yes ○ No

Occupation: _____ Email: _____

How did you find us? ○ Referred by: _____
○ Other (Please specify): _____

Have you ever received massage therapy before? ○ Yes ○ No

Did a health care practitioner refer you for massage therapy? ○ Yes ○ No

If yes, please provide their name and phone number: _____

Are you currently being seen by another health care practitioner? ○ Yes ○ No

Physician's name: _____ Phone: _____
(required by the College of Massage Therapists of Ontario)

Emergency contact:
Name: _____ Relationship: _____ Phone: _____

What is your general health status?
○ Poor ○ Fair ○ Good ○ Excellent

List injuries:

_____ _____ _____
Injury Date Nature

List surgeries:

_____ _____ _____
Surgery Date Nature

List internal pins, wires, artificial joints etc.:

_____ _____
Type Location

Please list all medications you are taking and corresponding conditions:
(Including prescription drugs, vitamins/minerals, herbal supplements, recreational drugs, birth control etc.)
Medication: _____ Condition: _____
Medication: _____ Condition: _____
Medication: _____ Condition: _____

Please list medical conditions you have been diagnosed with:

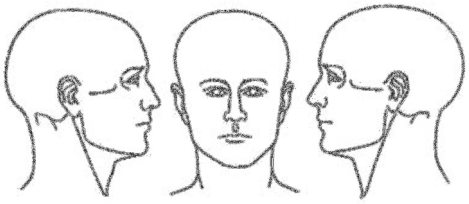
_____ _____
Diagnosis Date

Please list allergies and primary reaction:

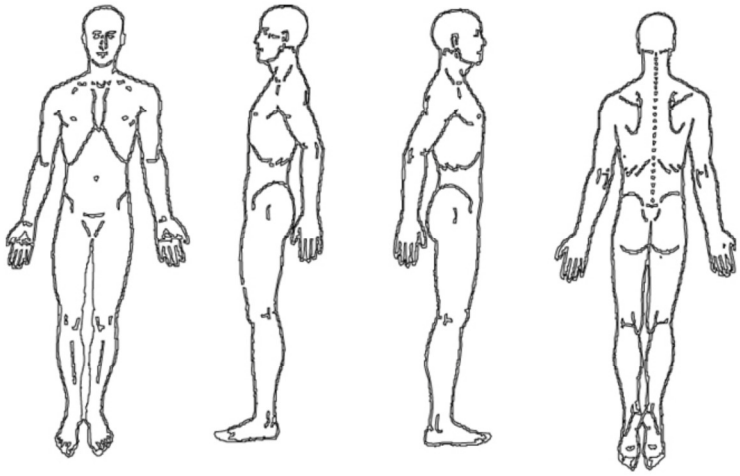
_____ _____
Allergy Reaction

_____ _____
Allergy Reaction

Please indicate on the diagrams the nature of your symptoms according to the legend below.



Aching	◯
Stabbing	X
Shooting	>
Burning	#
Numb	~



Please indicate conditions you are currently experiencing, or have experienced regularly in the past.

Musculoskeletal

- ○ Scoliosis
- ○ Bursitis
- ○ Tendonitis
- ○ Sprain _____
- ○ Strain _____
- ○ Edema/ Swelling _____
- ○ Sciatic pain
- ○ Arthritis _____
- ○ TMJ
- ○ Degenerating disc
- ○ Osteoporosis
- ○ Fracture _____
- ○ Fibromyalgia
- ○ Chronic fatigue
- ○ Whiplash
- ○ Other _____

Head

- ○ Tension headache
- ○ Cluster headache
- ○ Migraines
- ○ Vision problems
- ○ Dizziness/ Vertigo
- ○ Loss of balance
- ○ Tinnitus (ringing in ears)
- ○ Hearing problems
- ○ Epilepsy/ Seizures
- ○ Loss of smell
- ○ Other _____

Skin/ Hair

- ○ Itching/ Rashes
- ○ Eczema/ Psoriasis
- ○ Plantar warts
- ○ Athletes foot
- ○ Sensitive skin
- ○ Bruise easily
- ○ Dry skin/ scalp
- ○ Other _____

Cardiovascular

- ○ High blood pressure
- ○ Low blood pressure
- ○ Hemophilia
- ○ Heart attack
- ○ Varicose/ Spider Veins
- ○ Stroke/ CVA
- ○ Pacemaker
- ○ Heart disease
- ○ Raynaud's
- ○ Fainting
- ○ Other (specify)

_____

Respiratory

- ○ Chronic cough
- ○ Shortness of breath
- ○ Bronchitis
- ○ Asthma
- ○ Emphysema
- ○ Pneumonia
- ○ Bronchitis
- ○ Tuberculosis
- ○ Other (specify)

_____

Gynecological

- ○ Irregular periods
- ○ Painful periods
- ○ Fibroids
- ○ light/ heavy periods
- ○ Endometriosis
- ○ Infertility
- ○ Currently pregnant
  Weeks _____
  Due date: _____
- ○ Menopause
  Date: _____
- ○ Other

_____

Digestive

- ○ IBS
- ○ Ulcers
- ○ Constipation
- ○ Crohn's / Colitis
- ○ Kidney / Bladder
- ○ Liver / Gallbladder
- ○ Liver / Gallbladder
- ○ Other

_____

Infections

- ○ Hepatitis
- ○ Aids
- ○ Tuberculosis
- ○ HIV/ Aids
- ○ Herpes / Shingles
- ○ Skin infection (please specify)

_____

- ○ Other (specify)

_____

Other

- ○ Loss of sensation
- ○ Cancer
- ○ Diabetes
  Daily insulin required?
  ○ Yes ○ No
- ○ AIDS/ HIV
- ○ Hepatitis
- ○ Implants

_____

- ○ Other

_____

Is there a family history of any of the above conditions? ○ Yes ○ No _____

Consent Information

We want to ensure that you fully understand the services we are providing you with, the fees involved, and what we do with the personal information we collect from you. Please read the following information carefully, and indicate your understanding by signing in the space provided below. We will be happy to answer any questions you may have.

Consent for Treatment

I have read and understand all of the associated forms, answered them truthfully and to the best of my knowledge, and fully consent to treatment at BusyBodies Health. I have discussed and understand the nature of the treatment, the risks involved, and the importance of assessment and reassessment with my therapist. I understand that I have the right to modify or stop the treatment at any time. I understand that it is my responsibility to update BusyBodies Health of any changes to my personal or medical information and that I will be required to update my client intake information once per year.

Consent for fees and cancellation

I am aware of the fees and understand that I am responsible for payment at the latest on the day I receive the treatment. I understand that there is a 24-hour cancellation policy and if I fail to notify the clinic I may be charged for my session. I understand that the fee includes time with the therapist, which may include assessment, treatment, home care prescriptions, or advice of a related nature. I understand that it is my responsibility to review the fees policy listed on www.busybodieshealth.com

Consent for Personal Information

I understand that in order to provide me with the services I am seeking; BusyBodies Health will collect some personal information about me. I have reviewed BusyBodies Health's privacy policy about the collection, use and disclosure of personal information. I understand how the privacy policy applies to me. I understand that that there are rare exceptions to these commitments of privacy as explained in the privacy policy. Additional information is available on www.busybodieshealth.com

Consent for providing/obtaining information

On occasions, depending on the medical information you provide to use, we may request to communicate with your physician or another healthcare practitioner to ensure your safety. Your written permission is required prior to release of any information to a third party. If you permit us to share information with your other health care practitioners please check off one of the following. You have the right to revoke this request at any time.

○ Yes ○ No	I would like you to share or obtain assessment and treatment notes from my file to or from the health care providers I have listed above for the purpose of open communication for the benefit of my overall health.

Consent for promotions and special offers

I understand that if I do not check off the following boxes I will receive the following:

○ Yes ○ No	I would like to receive email/mail notices of promotions and special offers from BusyBodies Health so that I can stay on top of events, seminars/workshops, and newly acquired services. I understand that I have the opportunity to remove myself from these notices at any time.

I hereby agree to BusyBodies collecting, using and disclosing my personal information only with my expressed written authorization. I have been given the opportunity to ask questions and they have been answered to my satisfaction. And I have signed on this _____ day of _____.

Day Month Year

X _____ _____

Signature Name (Please Print)