Glenmore Chiropractic - Massage Intake

Personal Information:

Name: _____ Address: _____

City: _____ Province: _____ Postal Code: _____

Primary Phone #:_____ E-mail: _____

Date of Birth: _____ Gender: _____ Sex:_____

Name of Emergency Contact:_____ Relationship:_____

Phone of Emergency Contact:_____

Family Physician:_____ Personal Health Number:_____

Employer: _____ Occupation:_____

Massage Objectives:

Area of Complaint:

- ☐ Neck
- ☐ Abdomen
- ☐ Hip(s)
- ☐ Upper Back
- ☐ Arm(s)
- ☐ Leg(s)
- ☐ Lower Back
- ☐ Shoulder(s)
- ☐ Other

Other (please explain):_____

Reason for Massage:

- ☐ Relaxation
- ☐ Chronic Pain
- ☐ Muscle Tension
- ☐ General Soreness
- ☐ Stress Management
- ☐ Nerve Pain (numbness/tingling/shooting pain)
- ☐ Specific acute pain
- ☐ Self Care
- ☐ Other

Other (please explain):_____

General Information:

List any medications/vitamins you are taking: _____

List any surgeries/medical procedures:_____

Have you had a massage before? □ Yes □No

Overall how would you rate your level of stress?

□ Low □ Medium □ High □ Other:_____

Overall how would you rate your level of activity?

□ Active □ Moderate □ Sedentary □ Other:_____

Do you have (or have had) any of the following conditions?

- ☐ Cancer
- ☐ Diabetes
- ☐ Neuropathy
- ☐ Heart Attack
- ☐ Sprains or Strains
- ☐ Headaches/Migraines
- ☐ High/Low Blood Pressure
- ☐ Fibromyalgia
- ☐ Kidney Dsyfunction
- ☐ Arthritis
- ☐ Joint Replacement(s)
- ☐ Stroke
- ☐ Blood Clots
- ☐ Other

Other (please explain):_____

Do you perform any repetitive tasks? (work/hobby/sport) □ Yes □No

Please explain:_____

Allergies and Sensitivities:

□ Allergies (please list) □Sensitive Skin (I use organic coconut oil)

□Sensitive to Smells (Are essential oils in a diffuser okay?)

Please explain:_____

Are you pregnant? □ Yes □No

If yes, how many weeks?_____

Any other health concerns I should be aware of? □ Yes □No

If yes, please list:_____

_____ _____

Date Signature