NOVO HEALTHNET LIMITED

MASSAGE THERAPIST INTAKE FORM (PLEASE PRINT)

PATIENT INFORMATION

TITLE:	FIRST: MIDDLE:	LAST:	DOB:
STREET ADDRESS:		CITY:	POSTAL CODE:
P.O. BOX:	PRIMARY TEL:	SECONDARY TEL:	
EMAIL ADDRESS:		**Your email address will only be used by our clinic to communicate with you. It will not be sold or distributed.**	
EMERGENCY CONTACT NAME & NUMBER:	OCCUPATION:	HEIGHT:	
DOCTOR:	ADDRESS:	TEL:	FAX:
REFERRAL DETAILS:	(PLEASE TELL US HOW YOU HEARD OF BACK ON TRACK)		

Have you ever experienced a Professional Massage Therapy Treatment before? YES ☐ NO ☐ **When?**

HEALTH HISTORY: Please indicate conditions you are experiencing, or have experienced:

Head/Neck
__ Vision (loss) problems
__ Ear (Hearing) problems
__ Jaw (TMJ) problems
__ Headache/Migraine

Respiratory
__Chronic cough
__Shortness of breath
__Bronchitis
__Asthma
__Emphysema
__Sinus problems
__Smoking

Skin
__Skin Condition:
Type: _____
__Rashes/Bruise easily

Infections
__Hepatitis
__TB
__HIV, AIDS
__Herpes
__Plantar Warts
Other: _____

Cardiovascular
__High/Low Blood Pressure
__Chronic Congestive Heart Failure
__Heart Attack
__Phlebitis
__Stroke/CVA
__Pacemaker or other
__Heart Diseases
__Bleeding Disorders
__Varicose Veins
__Cancer
__Liver
__Gallbladder
__Kidney
__Insomnia
__Arthritis:

Women
__Pregnancy
Due Date: _____
__Menstrual Problems
__C-section
__Gynecological Surgery
Type: _____
__Menopause

Soft Tissue/ Joint Discomfort & Nature
__Neck:_____
__Upper Back: _____
__Low Back: _____
__Mid Back: _____
__Shoulders:_____
__Arms:_____
__Hands/wrists: _____
__Legs/knees: _____
__Ankles:_____
__Fractures
Location: _____
Date: _____
__Dislocations
Location: _____
Date: _____

Other Conditions
__Loss of Sensation
__Diabetes (onset)
__Allergies
Type: _____
__Osteoporosis
__Epilepsy
__Cancer
__Liver
__Gallbladder
__Kidney
__Insomnia
__Arthritis
Areas: _____
__Stress
__Scoliosis
__Hyper/Hypo
Lordosis/Kyphosis (circle)

MEDICATIONS: _____
_____
_____
_____
_____

Surgeries? If so, the nature and when: _____

Motor Vehicle Accident? If so, the nature and when: _____

Of Special Note: (Presence of internal pins, wires, artificial joints, special equipment such as wheel chair, crutches, walker, etc)

_____

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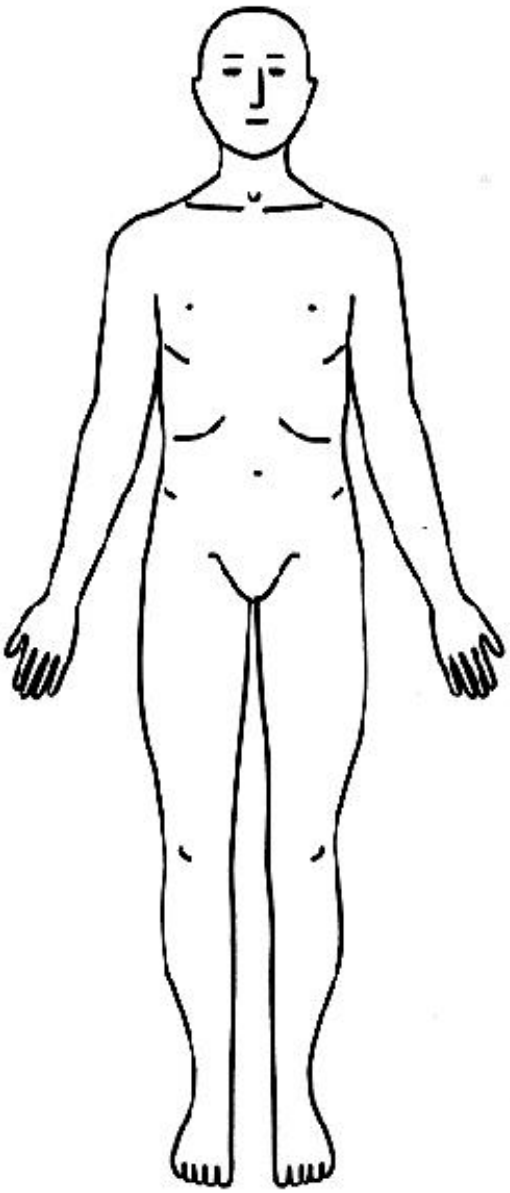
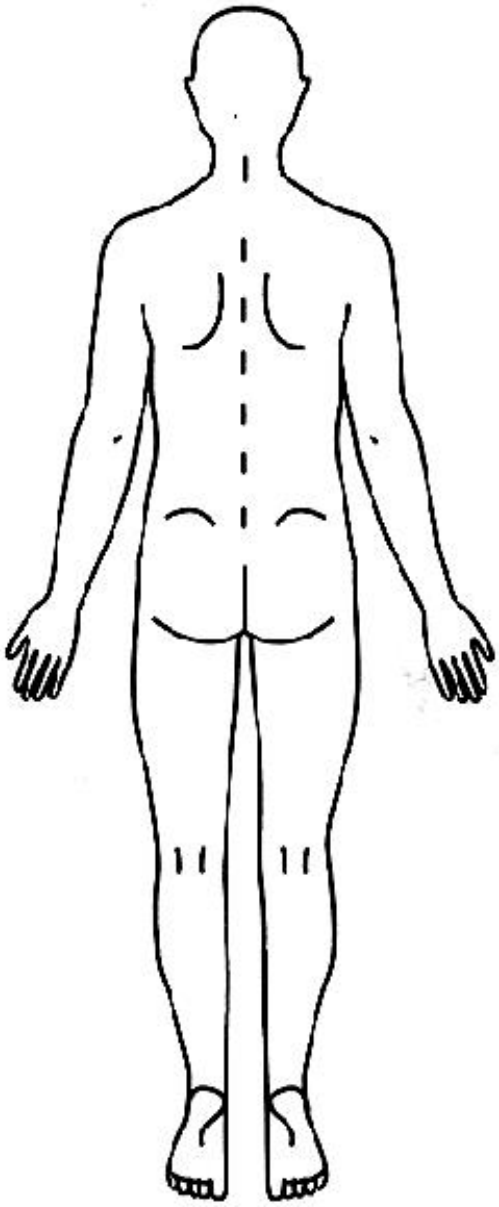
Achy or Constant Pain	XXX
Sharp Pain	****
Stiffness	////
Numbness	ooo
Other	____

Mark the area on the picture below with the appropriate symbol to best illustrate your symptoms.





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MASSAGE THERAPIST INFORMED CONSENT

As a matter of ethics and law there is an obligation, prior to examination and treatment, to disclose any material risk to the patient to obtain a valid informed consent. As part of the massage treatments, certain procedures and devices may be utilized such as the use of heat, ice, electrotherapy, ultrasound, massage and manual therapy. As part of the rehabilitation program (kinesiologist, occupational therapist or physical therapist assistant) certain testing procedures, devices and equipment may be utilized such as weight machines, exercise, cardiovascular work and functional tasks. I have had the opportunity to discuss with the massage therapist and/or other clinical staff, the nature and purpose of treatments. I understand the results are not guaranteed. I further understand, and I am informed that there are some very slight risks to treatments, including, but not limited to, muscle strains, sprains, disc injuries, and burns have been made aware that there are remote chances of injury and that appropriate tests will be performed to help identify if I may be susceptible to risk or injury

Patient Signature: _____ Date: _____

Parent/Guardian Signature: _____ Date: _____

Witness Signature: _____ Date: _____

NOVO HEALTHNET LIMITED

CONFIDENTIAL CONSENT, AUTHORIZATION & DIRECTION TO DISCLOSE PERSONAL INFORMATION

I, _____
(Print Full Name)

Of_____
(Print Full Address)

Hereby consent to the sharing and / or exchange of written and/or verbal information between Novo Healthnet Limited and:

_____

_____

_____
(Print full names and institutions of affiliation)

In respect of

_____
(Print name of the client)

_____
(Date of birth)

Information to be released related to the above-named injury or illness and pertains to the development of treatment and nutritional plans.

I understand that this consent is subject to revocation at any time, except for such action that has already been taken.

A photocopy of this authorization shall have the same validity as the original.

Dated the _____ day of _____, 20____

_____ _____

(Witness) **(Signature)**