TAILOR MADE WELLNESS CLINIC

#200, 85 Cranford Way
Sherwood Park, AB T8H 0H9
Phone: 780-464-5220

www.tailormadewellness.com

Massage Therapy Intake Form

Alberta Healthcare # (required for clinic paperwork purposes)	

Personal Information			
Name		Date	
Address			
City, Province		Postal Code	
Phone.		OK to leave messages? ☐ Yes / ☐ No	
Alternate Phone:		OK to leave messages? ☐ Yes / ☐ No	
Birth Date:		Gender:	
Age:	Height:	Weight:	☐ Right handed / ☐ Left handed
Emergency Contact Information			
Emergency Contact:			
Phone		Relationship	
Medical doctor:			
Chiropractor:			
Work Information			
Occupation			
Employer			
Address			
City / Province		Phone	

Medications (including herbs and supplements)	Allergies
☐ I am currently not taking any medications	

General Health History

Please check all additional concerns that apply: **How long?** **How long?**

	How long?		How long?
☐ High blood pressure		☐ Allergies	
☐ Digestive disorders		☐ Asthma	
☐ Vascular problems		☐ Cancer	
☐ Headaches/migraines		☐ Tropical diseases	
☐ Skin problems		☐ Blood disorders	
☐ Diabetes		☐ Heart disease	
☐ Dizziness		☐ Kidney disease	
☐ Hemophilia		☐ Psychological/emotional disorders	

Have you ever received chiropractic treatment? Yes ☐ / No ☐

Chiropractor's Name ______________________

When was your last treatment? Results ☐ Excellent ☐ Good ☐ Fair

Lifestyle / Habits

Rate your sleep habits ☐ 4–6 hours/night ☐ 6–8 hours/night ☐ 8–10 hours/night ☐ 10+ hours/night

Rate your diet ☐ Poor ☐ Fair ☐ Medium ☐ Good ☐ Excellent

Do you eat regularly? ☐ Breakfast ☐ Lunch ☐ Dinner ☐ Snacking

Are you pregnant? If yes, how far along?

Any other health concerns?

Falls / Operations / Traumas

Falls / Accidents (please list in space provided) ______________________

Surgery (please list in space provided) ______________________

Massage History

Recent motor vehicle accident Yes ☐ / No ☐ Date

Have you received massage therapy treatment before? Yes ☐ / No ☐

Results ☐ Excellent ☐ Good ☐ Fair When was your last treatment?

Why did you previously seek massage treatment(s)?

Chief Concern

What is your primary concern today? ______________________

What is your most significant discomfort today?

How long has this discomfort been occurring? ______________________

What makes it better or worse? ______________________

Have you had similar conditions in the past? Yes ☐ / No ☐ Date: ____________

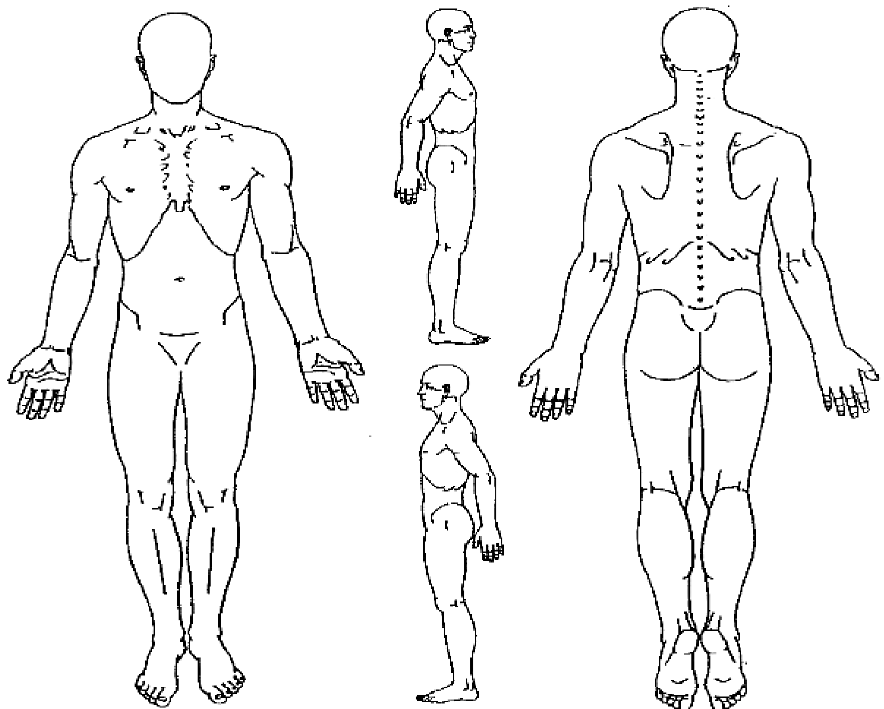
What are your expectations in coming here today? ______________________

Pain Drawing

It is important that your registered massage therapist knows where you have stiffness, numbness, tingling and any type of pain. Please mark the areas on the figures below that correspond to any pain or altered sensation you're experiencing.

1. Draw in your face.
2. Show area(s) of pain or unusual feeling. If the pain you're experiencing travels or "shoots" use arrows to indicate how far it travels.
3. Use the appropriate symbols to mark the area(s) on this body where you feel the described sensations. Include all affected areas.

Numbness	*N N N N N*
Tingling	*T T T T T*
Stiffness	*S S S S S*
Pins and Needles	*P P P P P*
Burning	*X X X X X*
Aching	*A A A A A*
Stabbing	*/ / / / / /*



Informed Consent

I, __________________________ release the massage practitioner from any and all liability from problems arising from the treatment as a result of information not given or incorrectly given in this case history.

Massages are booked on 30-minute and 60-minute increments only. Clients will be charged accordingly.

Tailor Made Wellness Clinic has a 24-hour cancellation policy. If for any reason you need to cancel or reschedule your appointment, please allow 24-hour notice. We reserve the right to charge clients for missed appointments.

Patient's Name (print)	**Patient's Signature**	**Date**