



Ottawa Integrative Health Centre
1129 Carling Ave., Ottawa, ON K1Y 4G6
P: 798-1000 F: 798-9995 E: oihc@bellnet.ca

Registered Massage Therapy Intake

Patient Information

Name _____ Date _____

Address _____

City _____ Province _____ Postal Code _____

Home Phone _____ Cell Phone _____

Work Phone _____ E-Mail _____

Date of Birth *day* _____ *month* _____ *year* _____ Age _____

Occupation _____

Family Doctor _____

Indicate below any other health care professional(s) that you currently consult.

Physiotherapist Chiropractor MD Naturopath Other _____

Referred By _____

Reason for Massage Therapy Treatment _____

Emergency Contact Information

Name _____ Relation _____

Phone _____ E-Mail _____

The Ottawa Integrative Health Centre requires an accurate and up-to-date health history to ensure appropriate and safe massage treatment. If your health status or information changes at any point please let the therapist know. This form will be updated yearly.

All of the information, disclosed in this form or kept on file, is confidential according to the privacy policy. If you have any questions feel free to ask them of the therapist at any time. If you require your information to be released to another party, a written authorization will be required.



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(Instructions) To the left of each question below please indicate whether you have experienced this problem in the past (check the box under 'P'), if you are currently experiencing the problem (check the box under 'C') or if there is a family history of this problem (check the box under 'F'). Include any additional information that might be helpful on the line provided below each question.

PCF

Loss of vision, hearing or skin sensation

Cardiovascular conditions
such as high or low blood pressure, heart disease, stroke or TIA, congestive heart failure, heart attack, phlebitis, varicose veins or cerebro-vascular accident

Respiratory conditions
such as asthma, emphysema, bronchitis, shortness of breath or chronic cough

Hypersensitivities or allergies

Life-threatening allergies

Head, ear or eye conditions
such as migraines, headaches, earaches, sinus infections, dizziness, blurred or limited vision

Skin conditions
such as rashes, cold sores or eczema,

Soft tissue or joint discomfort
of the neck, upper back, mid back, low back, shoulders, arms, legs, knees or other



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Pins, wires, prosthetics, pacemaker, contact lens, artificial joints, glasses, special equipment or other _____

Infectious conditions such as tuberculosis, hepatitis, HIV, herpes or other _____

Other medical conditions such as diabetes, epilepsy, cancer, hemophilia, kidney disease, MS, Parkinson's disease, osteoporosis, osteoarthritis, rheumatoid arthritis or other _____

Please list any prescribed medications, over-the-counter drugs or herbal or natural supplements that you are currently taking, and the reason for taking them.

Describe any accidents, injuries, surgeries or major illnesses in your life.

If you have consulted a Registered Massage Therapist in the past list the reason(s).

Is there anything that you feel is important that has not been covered here?

General Health Questions

Are you currently pregnant? (due date _____)

Are you currently peri- or meno-pausal?

Are you currently post menopausal?

Do you smoke? yes no

Do you exercise regularly? yes no

Do you have regular, balanced eating habits? yes no

Rate your energy level high low just right

How do you sleep? not enough not restful well

Rate your overall health poor below avg. avg. above avg. excellent

The information listed above is complete and accurate. I understand that a record will be kept of the health services provided to me, and that it will be kept confidential and will not be released to others unless so directed by myself unless the law requires it.

Client Signature _____ Date _____