Health MOMENTUM CENTRE FOR THERAPEUTIC MEDICINE

Massage Therapy Medical History Intake Form

Candace Kakowchyk: ck.osteo@gmail.com

PLEASE COMPLETE THIS FORM IN FULL. ALL INFORMATION IS STRICTLY CONFIDENTIAL.

Date:_____ **Email:**_____

Name:_____ **Age:** ___ **Date of Birth:**_____
Last **First**

Home Address: _____

Province: _____ **Postal Code:** _____ **Occupation:** _____

Home Phone #: _____ **Business/Cell Phone #:** _____

General Practitioner: _____ **Address:** _____ **Phone #:** _____

Date of Last Medical Exam: _____ **Referred By:** _____

List of Past Surgeries, including Dates: **List of Past Injuries/Accidents, including dates:**

_____ _____

_____ _____

_____ _____

_____ _____

Please list ALL medications you are currently taking, OR have taken in the last six months:

_____
Medication/Reason for Taking

_____
Medication/Reason for Taking

Are you currently undergoing any forms of treatment? Please detail.

_____

_____

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Do you exercise regularly (3 Times Per Week): Yes No

If you experience any of the following symptoms during, or shortly after, physical activity please circle:

Extreme Muscle Soreness	Difficulty Breathing	Headaches	Chest Pain
Extreme Weakness/Fatigue	Abdominal Discomfort	Dizziness	Other:

Is there anything else you think is important pertaining to your complaint?

_____

_____

_____

Are you pregnant? _____ **If Yes, what trimester?** _____

Number of Children: _____ **Complications with Pregnancy?** _____

Complications with Labour & Delivery? _____

Do you have any surgical implants, such as artificial joints, pins, needles, metal plates, pacemaker, other? If yes, where?

_____

_____

How would you describe your present state of health? _____

_____

What is your main complaint? _____

_____

_____

ADDRESS 275 LANCASTER ST W • KITCHENER, ON • N2H 4V2
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PLEASE CHECK ANY PAST, OR CURRENT, HEALTH PROBLEMS

Digestive System:	Gynecological/Urological System:	Cardiovascular System:
☐ Heart Burn ☐ GERD ☐ Ulcers (Location: _____ _____) ☐ Gas/Bloating ☐ Feeling of Heaviness ☐ Nausea ☐ Loss of Appetite ☐ Increased Appetite ☐ Dysphagia (Difficulty Swallowing) ☐ Food Allergies ☐ Hemorrhoids ☐ Cirrhosis ☐ Hepatitis (Type:_____) ☐ Gallstones ☐ Diarrhea ☐ Constipation ☐ IBS ☐ Celiac Disease ☐ Chron's Disease ☐ Ulcerative Colitis	**Women:** ☐ Dysmenorrhea ☐ Irregular Menstruation ☐ Fibroids/Uterine Cysts ☐ Pelvic Inflammatory Disease ☐ Endometriosis ☐ IUD ☐ Menopause ☐ Loss of Pregnancy ☐ Ovarian/Cervical Cancer ☐ Herpes/STDs **Men:** ☐ Prostatitis ☐ Sexual Dysfunction ☐ Benign Prostatic Hypertrophy ☐ Prostate Cancer ☐ Epididymitis/Orchitis ☐ Herpes/STDs	☐ Phlebitis ☐ Varicose Veins ☐ Chest Pain/Cramps ☐ Angina ☐ High Blood Pressure ☐ Low Blood Pressure ☐ High Cholesterol ☐ Arrhythmia ☐ Myocardial Infarction (Heart Attack) ☐ Heart Palpitations ☐ Numbness ☐ Cold Hands/Feet ☐ Aneurysm ☐ CVA/Stroke ☐ Atherosclerosis ☐ Anemia ☐ Hemophilia ☐ Congestive Heart Failure
Respiratory System:	**Nervous System:**	**Musculoskeletal System:**
☐ Asthma ☐ Bronchitis ☐ Pneumonia ☐ Emphysema ☐ Allergies ☐ Cold/Flu ☐ Dyspnea (Shortness of Breath) ☐ COPD ☐ Pulmonary Embolism ☐ Pulmonary Edema ☐ Tuberculosis	☐ Epilepsy ☐ Headaches ☐ Migraines ☐ Dizziness ☐ Vertigo ☐ Fainting ☐ Balance Problems ☐ Neuralgia ☐ Paralysis ☐ Multiple Sclerosis ☐ Parkinson's ☐ Neuritis	☐ Pain (Location: _____) ☐ Bursitis ☐ Tendonitis ☐ Rheumatoid Arthritis ☐ Osteoarthritis ☐ Dislocation ☐ Muscle/Joint Strain ☐ Weakness/Loss of Strength ☐ Clumsiness ☐ Ankylosing Spondylitis ☐ Gout

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Immune/Lymphatic System:	Urinary System:	Ear/Nose/Throat:
☐ Systemic Lupus Erythematosus ☐ Reiter's Syndrome ☐ Edema ☐ HIV/AIDS ☐ Lymphoma ☐ Swollen Lymph Nodes (Location: _____)	☐ Urinary Tract Infection ☐ Dysuria (Painful Urination) ☐ Polyuria ☐ Nocturia ☐ Burning on Urination ☐ Kidney Stones ☐ Kidney Failure ☐ Incontinence ☐ Ptosis of Bladder ☐ Polycystic Kidney Disease	☐ Rhinitis/Sinusitis ☐ Polyps ☐ Otitis/Ear Infections ☐ Tonsillitis/Strep Throat ☐ Tinnitus ☐ Hearing Loss ☐ Myopia (Near Sighted) ☐ Hyperopia (Far Sighted) ☐ Astigmatism ☐ Conjunctivitis (Pink Eye) ☐ Glaucoma ☐ Fillings/Root Canals ☐ Tooth Extractions ☐ Orthodontic Work ☐ Dental Implants ☐ Tubes in Ears ☐ Dental Appliances ☐ Reconstructive Surgery
Integumentary System:	**Endocrine System:**	**Other:**
☐ Scleroderma ☐ Acne ☐ Herpes/Cold Sores ☐ Dermatitis ☐ Eczema ☐ Psoriasis ☐ Parasites (incl. Ring Worm)	☐ Pancreatic Disorder ☐ Pituitary Disorder ☐ Hyperthyroidism ☐ Hypothyroidism ☐ Pineal Gland Disorders ☐ Menopause ☐ Depression	☐ Osteoporosis ☐ Cancer (Type:_____) ☐ Undiagnosed Lump ☐ Inguinal Hernia ☐ Hiatal Hernia ☐ Umbilical Hernia ☐ Other: _____ _____

I Certify the Information Provided in this Form is True and Accurately Reflects My Past, and Present, Health Status.

_____ _____

Patient (or Guardian) Signature **Date**

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Consent to Assessment and Treatment

I _____ consent to assessment, and treatment, for my present complaint. I understand I have been asked to wear loose fitting clothing for purposes of this assessment and/or treatment.

I further understand I may stop assessment and/or treatment at any time, and for any reason.

Further, I have been informed, by Candace Kakowchyk, the treatment I will receive is Massage Therapy, which includes advanced Massage Therapy techniques.

My therapist has provided me with all relevant information to the treatment and I understand the benefits, risks and side effects of this treatment plan. I have also been provided, and understand, alternative courses of treatment where applicable. All of my questions regarding all aspects of the assessment, treatment and treatment plan, have been addressed and answered.

_____ _____

Patient Signature Date

Cancellation Policy

By signing this form the patient agrees to give **48 business hours** notice when canceling appointments. The patient also agrees if **48 business hours** notice is not given they will be responsible for the full treatment fee.

Receipts issued for missed appointments will state **Missed Appointment**, and further appointments will not be scheduled until payment is received.

_____ _____

Patient Signature Date

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Privacy Policy

I understand all information collected on this form is for the sole purpose and use of my therapist, and is collected in accordance with the Personal Health Information Protection Act (PHIPA, 2004) and the Personal Information Protection and Electronic Documents Act (PIPEDA, 2000). My name, address, email and phone number are collected in order for my therapist to contact me regarding any appointment changes, payment inquiries, or news and changes applicable to the clinic. They will not be solicited or sold to any outside source, and will remain on the clinic premises at all times. I understand this information may, however, be accessed by regulatory authorities as outlined in the Regulated Health Professionals Act (RHPA), the Registered Massage Therapists Association of Ontario (RMTAO), and/or the College of Massage Therapists of Ontario (CMTO).

I understand my therapist will not, under any condition, supply my insurer, doctor, or anyone else, with my confidential medical and treatment history without first receiving my express written consent. The same applies if my therapist requires permission to contact my doctor in the event more details are needed in order to treat my present condition.

_____ _____

Patient Signature Date

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