Ascent Integrative Health
Registered Massage Therapy Intake Form

Welcome to Ascent! We are honoured to partner in your health goals. To assist us in providing you with the best possible care, please fill out the following questionnaire accurately and thoroughly before your first appointment. All information is strictly confidential.

Patient Information

Today's Date: _____ Gender: _____

Full Name: _____ Preferred Name: _____

Address: _____ Postal Code: _____ City: _____ Prov: _____

Home Phone: _____ Cell: _____ Work: _____

E-mail: _____ ☐ I would like to receive E-mails for appointment reminders, clinic information/ updates, promotional materials etc. *(please note you can opt-out at any time)*

Age: ____ Birthdate: (DD) ____ / (MM) ____ / (YY) ____ Alberta Health Care Number _____

Marital Status: _____ Occupation: _____ Employer: _____

Emergency Contact: _____ Relationship: _____ Phone No: _____

Is this a WCB injury: ☐ No ☐ Yes Are your injuries related to a Motor Vehicle Accident? ☐ No ☐ Yes

If yes, when did the accident occur? _____

Medical Information

Family Medical Doctor's Name: _____ Clinic: _____

Date of Last MD Visit: _____ Reason: _____

What therapy have you previously received? ☐Chiropractic ☐Massage ☐Acupuncture ☐Physiotherapy

*Communication between healthcare providers can greatly improve the quality and safety of patient care. If necessary, do you consent to allow your health provider at Ascent to contact your medical doctor? ☐ No ☐Yes

Extended Health Benefits & Other Insurae

Do you have a private insurance plan? ☐ No ☐ Yes (Self) ☐ Yes (Spouse) ☐ Yes (Parent)

Name of primary policy holder (Spouse/Parent): _____

We offer direct billing to most benefit providers.

Name of benefit provider: _____ policy no. _____ Member No. _____

Group number (Alberta Blue Cross only.) _____

How Did You Find Us?

☐ Referred by Friend/Family ☐ Referred by Medical Doctor ☐ Internet/Website ☐ Walk by

☐ Other: _____ Whom may we thank for this referral? _____

Purpose of Visit?

What is your main health concern or complaint? _____

When did your symptoms first begin? _____

Have you had this before? ☐ No ☐ Yes ; Who did you see for treatment? _____

Is it getting: ☐ Worse ☐ Better ☐ Not Changing

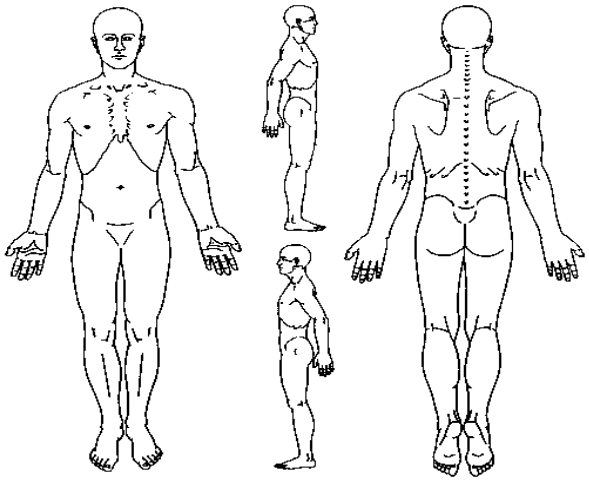
What do you hope to gain from your treatment here?

☐ **Resolve Pain:** Get me moving pain-free

☐ **Optimize Recovery:** Get me moving pain-free and provide guidance and rehabilitation to restore normal function

☐ **Improve Overall Health:** Get me moving pain-free, provide guidance and rehabilitation to restore normal function and help me be proactive in my health and wellness

On the diagram(s) below, please circle the area(s) that applies most to where you experience symptoms or feel pain.



Use these letters to describe the pain:
S sharp **D** dull **A** achy **H** hot **C** cold
N numb/tingling **DB** deep and boring
V variable

Please rate your pain from **0-10** (with 0 being LEAST and 10 being WORST): _____

When do you feel the pain? ☐ Constantly ☐ Intermittently ☐ At Night ☐ In the Morning
Does the pain radiate down your legs or arms? ☐ No ☐ Yes

What relieves your pain?
☐ Rest ☐ Ice ☐ Massage ☐ Other: _____
☐ Movement ☐ Heat ☐ Medication: _____

Have you seen anyone else for this condition? ☐ No ☐ Yes: Who have you seen? _____
Have you had any imaging for this condition: ☐ X-Ray ☐ CT ☐ MRI ☐ Ultrasound Date: _____
Does this problem interfere with: ☐ Work ☐ Family & Social Life ☐ Sports & Hobbies ☐ Sleep
Do you have any secondary complaints? _____
On a scale of 1-5 please indicate your massage pressure preference:
☐ 1 (Low Intensity) ☐ 2 (Moderate Intensity) ☐ 3 (Medium Intensity) ☐ 4 (High Intensity) ☐ 5 (Extreme Intensity)

Health History

Please list any serious illnesses, injuries or surgeries and when they occurred: _____

_____

_____

Please list any medication you have taken in the past 6 months: _____

_____

Please list any allergies: _____

Do you have: High blood pressure: ☐ No ☐ Yes; High cholesterol ☐ No ☐ Yes

Family History

Is there a family history of:	Heart Disease	Stroke	Cancer	Diabetes	Arthritis	Other
Mother's Side:	☐	☐	☐	☐	☐	_____
Father's Side:	☐	☐	☐	☐	☐	_____

Review of Systems

Please check the box for any conditions or symptoms that you have had in the ***past six months.***

General
- ❑ Fainting
- ❑ Headaches
- ❑ Fever
- ❑ Excessive Sweating
- ❑ Loss of Weight
- ❑ Night Pain
- ❑ Loss of Sleep
- ❑ Anxiety/Nervous

Neurological
- ❑ Dizziness
- ❑ Blurred Vision
- ❑ Paralysis
- ❑ Numbness/Tingling
- ❑ Clumsiness
- ❑ Nausea
- ❑ Convulsions
- ❑ Loss of Balance

Genitourinary
- ❑ Trouble Urinating
- ❑ Blood in Urine/Stool
- ❑ Kidney Infection
- ❑ Prostate Trouble
- ❑ Painful Menstruation
- ❑ Irregular/Absent Cycle
- ❑ Painful Breasts
- ❑ Menopause

Respiratory
- ❑ Asthma
- ❑ Chronic Cough
- ❑ Difficulty Breathing
- ❑ Sinus Infections
- ❑ Spitting up Blood
- ❑ Spitting up Phlegm
- ❑ Sore Throat
- ❑ Frequent Colds

Cardiovascular
- ❑ Chest Pain
- ❑ Previous Heart Attack
- ❑ Previous Stroke
- ❑ Angina
- ❑ Ankle Swelling
- ❑ Poor Circulation
- ❑ Irregular Heartbeat
- ❑ Varicose Veins

Gastrointestinal
- ❑ Poor/Excessive Appetite
- ❑ Belching/Gas
- ❑ Vomiting
- ❑ IBS
- ❑ Constipation
- ❑ Diarrhea
- ❑ Crohn's
- ❑ Heartburn

Muscle & Joint
- ❑ Low Back Pain
- ❑ Mid Back Pain
- ❑ Neck Pain
- ❑ Shoulder/Arm Pain
- ❑ Elbow Pain
- ❑ Knee/Leg Pain
- ❑ Hip/Groin Pain
- ❑ Wrist/Hand Pain
- ❑ Ankle/Foot Pain
- ❑ TMJ/Jaw Pain
- ❑ Fibromyalgia
- ❑ Arthritis
- ❑ Disc Herniation
- ❑ Sciatica
- ❑ Gout

Eyes/Ears/Nose/Throat
- ❑ Earaches/Infection
- ❑ Ringing in Ears
- ❑ Hearing Difficulty
- ❑ Eye Pain
- ❑ Worsening Vision

Lifestyle

Are you currently a smoker? ❑ No ❑ Yes; How many per day?:_____ For how many years? _____

Did you smoke previously? ❑No ❑Yes; How long ago?: _____ For how many years? _____

Do you drink alcohol? ❑No ❑ Yes; How often? ❑ Daily ❑ Weekly ❑ Infrequently

Do you drink coffee? ☐No ☐Yes; How often? ☐ Daily ☐ Weekly ☐ Infrequently

Do you use recreational drugs? ☐ No ☐ Yes; How often? ☐Daily ☐Weekly ☐ Infrequently

What would you say about your diet? ❑ Needs significant improvement ❑Okay for now ❑ Very healthy

Do you exercise regularly? ☐ No ☐Yes; Type & Frequency: _____

What are your stress levels? ☐ Extreme ☐High ☐Moderate ☐ Low ☐ Very Minimal

ASCENT INTEGRATIVE HEALTH

IMPORTANT INFORMATION FOR MASSAGE PATIENTS

Informed Consent to Treatment
I understand that the massage I will receive at this Clinic is for the purposes of managing stress, relaxing my muscles, relieving tension and pain, and increasing circulation and energy flow. Their treatment will not include drugs or needles.

I understand that the massage therapist will not be diagnosing my problem, but will provide me with information that will direct me to an appropriate health care provider.,

I will inform my therapist of all my known health problems and will provide updates on any changes in my health.

In a few cases unpleasant after effects may occur. These could include muscle soreness, stiffness, headache or nausea and will be temporary in nature. The therapist will advise me on ways of minimizing this possibility.

I have had an opportunity to review this with the therapist, and have had all questions answered to my satisfaction. I hereby consent to treatment.

Cancellation policy for massage appointments
Our massage therapists are independent contractors and are not paid by the clinic for the massage services they provide. The cost of your massage therapy is based on the length of your scheduled treatment time with a particular therapist.
If an appointment is made but not kept, it affects not only the therapist but also other patients who could have used that same time. Please respect their valuable time by keeping your appointments.

<u>You will be charged for missed appointments unless the following occurs:</u>

- You call at least 24 hours in advance of your appointment
- Your appointment time can be filled by another person
- An unforeseen and unavoidable emergency occurs

Please note that insurance companies cannot be billed for missed appointments.

If you are scheduled for a one hour massage but arrive late you will be charged for the full amount of time that was scheduled. Please arrive early to prepare yourself for your massage.

If you have any questions or comments please direct them to your massage therapist.

NOW RELAX AND ENJOY

_____ _____

Patient/Guardian Signature Date