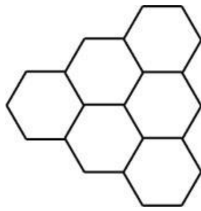


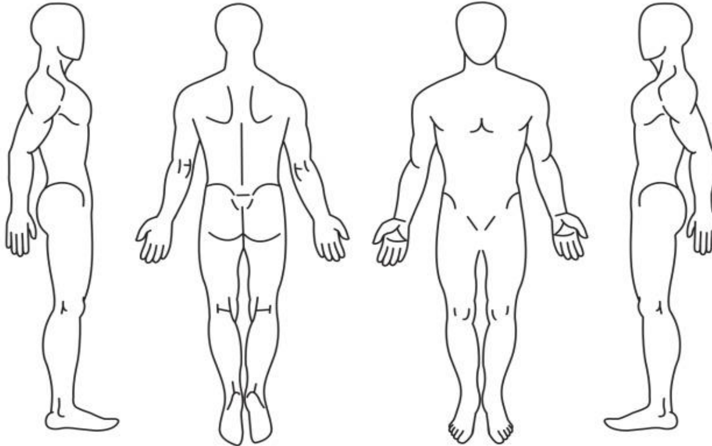
PHYSIOLOGIX HEALTH SERVICES

Massage Therapy Intake & Consent

All information requested will assist in treating you safely. All information provided is kept confidential & private unless we have your signed consent or as required by law.

Name: ______ Provincial Healthcare #: ______
Date of Birth: dd / mm / yy ______ Phone: ______
Address: ______ City & Postal Code: ______
Email: ______ Emergency Contact: Name & Number ______
Occupation: ______ Referral method: ______
Are you here due to a Motor Vehicle Accident? ☐ No ☐ Yes Claim # & Date of Loss ______
Are you here due to a WCB claim? ☐ No ☐ Yes Claim # & Date of Loss ______

1) Have you ever received a professional massage before? ☐ No ☐ Yes
2) Please let us know the top 2 reasons why you are seeking massage therapy: ______
3) Have you sought help from other fields of practice? ☐ No ☐ Yes
   ☐ Acupuncture ☐ Chiropractor ☐ Medical Physician ☐ Physical Therapist ☐ Other
4) Please circle the areas you would like us to focus on:



Indicate your symptoms:
☐ Dull Ache
☐ Numbness
☐ Pins & Needles
☐ Sharp Pains
☐ Soreness
☐ Tension

Have you had Surgery?
☐ No ☐ Yes

Are you Pregnant?
☐ No ☐ Yes

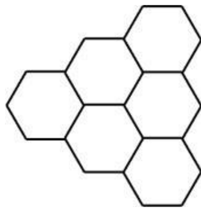
5) What aggravates your symptoms? ______
6) List all known allergies: ______
7) List current medications: ______
8) List any previous injuries: ______

Please Check off any applicable Medical History

Cardiovascular:	***Respiratory:***	***Infections:***	***Other:***		
☐ Low Blood Pressure	☐ Shortness of Breath	☐ AIDS	☐ Altered Sensation	☐ Disc Herniation	☐ Limitation of movement
☐ High Blood Pressure	☐ Asthma	☐ Herpes	☐ Anemia	☐ Dizziness	☐ Migraines
☐ Heart Attack	☐ Bronchitis	☐ Hepatitis	☐ Arthritis	☐ Double Vision	☐ Multiple Sclerosis
☐ Heart Disease	☐ Emphysema	☐ HIV	☐ Bleeding Disorder	☐ Eczema	☐ Nausea
☐ Congestive Heart Failure	☐ Chronic Cough	☐ Shingles	☐ Blood Clots	☐ Epilepsy	☐ Osteoporosis
☐ Stroke/CVA	***Medical Devices:***	☐ Contagious Skin Condition	☐ Blurred Vision	☐ Gastrointestinal Problems	☐ Pinched Nerve(s)
☐ Phlebitis/Varicose Veins	☐ Pace Maker		☐ Cancer	☐ Hearing loss	☐ Psoriasis
☐ Chest Pains	☐ VAD		☐ Crohn's Disease	☐ Indigestion	☐ Spinal Injury
	☐ Colostomy Bag			☐ Insomnia	☐ Tinnitus
				☐ Joint Pain	☐ Fibromyalgia

Other conditions not listed above: ______

#201, 6040 Andrews Way Edmonton, AB T6W 3S9
P: 587 499 3194 · F: 587 499 2466 · Email: rehab@physiologix.ca



PHYSIOLOGIX HEALTH SERVICES

Massage Therapy Information & Risks

Massage therapy is the manipulation of soft tissues of the body including muscles, connective tissues, tendons, ligaments & joints. Massage therapy is considered a complementary & alternative medicine. Studies of benefits demonstrate that massage is an effective treatment for reducing stress, pain & muscle tension. Despite its benefits, massage is not meant as a replacement for regular medical care or medication. If you have any medical concerns, please consult with your medical physician first. The massage therapist is not liable for any issues that arise as a result of information not given or incorrectly given in the intake form.

As with all fields of practice, there are risks involved. Massage therapy can leave you feeling sore the next few days. You may also experience slight bruising, swelling, exhaustion, bowel movements, & urgency to urinate. These are all normal symptoms due to the manipulation of the soft tissue which can increase blood circulation & aid in removing toxins from the body. During a Massage therapy session, if at any point you are experiencing pain or discomfort, please speak up so that your therapist may adjust the pressure.

Cancellation Policy

All Registered Massage Therapists at PhysioLogix PT run their own practice & receive compensation solely from the services provided to their patients. Your appointment time has been reserved specifically for you & no one else. In courtesy of your therapist & your fellow patients, we require 24 hours notice for any changes or cancellations to your appointment. In the absence of 24 hours notice, patients are subject to a fee of up to 40% of the cost of session booked. All "No Show" appointments are subject to the full cost of the session missed. Please note that your insurance will not cover any missed or cancelled appointment fees.

By signing below, I have provided my full knowledge of the information requested. I have read, understand & agree that withholding or incorrect medical information may lead to contraindications & can be dangerous to my health. The therapist is not liable for any issues arising from contraindications as a result of misinformation of medical history as provided by me. I have read & agree to abide by the cancellation policy as stated above.

Patient Name: PRINT NAME ____________ **Massage Therapist:** PRINT NAME ____________

Patient Signature: ____________ **RMT Signature:** ____________

Signed on: DATE ____________