DYNAMIC BALANCE
Physiotherapy & Sports Injuries Centre

11 Gibb Street
Oshawa, ON L1H 2J9
T: 905-404-3434
F: 1-866-623-8188
E: info@dynamicbalancephysio.com

Massage Therapy – Intake Form

Welcome to DYNAMIC BALANCE PHYSIOTHERAPY & SPORTS INJURIES CENTRE. An accurate health history is important to ensure that it is safe for you to receive massage therapy. If your health status changes in the future, please let us know. All information is confidential and will only be released with written consent from you, as required by law.

Patient Information

Last Name:	First Name:	Date of Birth (DDMMYYYY)
Address:	City:	Postal Code:
Home Phone:	Cell Phone:	Work Phone:
Employer:	Occupation:	
Family Doctor/Medical Practitioner Name: Phone Number:	Doctors Clinic Address	
Have you received Massage Therapy before? ☐ YES ☐ NO		
How did you hear about our clinic?		
How would you describe your overall health (please select ONE) ☐ Excellent ☐ Good ☐ Fair ☐ Poor		
Are you currently receiving treatment from another healthcare professional? ☐ YES ☐ NO If "YES", identify provide and condition being treated:		
Are you currently taking any medications? ☐ YES ☐ NO If "YES" list your current medications and condition it treats:		
Previous Surgery (Nature and Date):		
Previous Injuries (Nature and Date):		
Other Medical Conditions:		
Any additional Info (Internal pins, wires, artificial joints, special equipment etc):		

Extended Health Care Information (Benefits)

Name of Insurance Company	Name of Employee	
Name of Employer	Contract/Policy Number	Certificate/ID Number

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Health History: Please indicate conditions you are experiencing or have experience in the past:

Cardiovascular	**Respiratory**	**Gastrointestinal**	**Bone/Joints/Soft Tissue**
☐ High/Low blood pressure	☐ Chronic cough	☐ Diarrhea	☐ Osteoporosis
☐ Chronic CHF	☐ Shortness of breath	☐ Constipation	☐ Metal implants
☐ Heart attack	☐ Bronchitis	☐ Heartburn	☐ Muscular disease
☐ Phlebitis/Varicose veins	☐ Asthma	☐ Celiac Disease	☐ Scoliosis
☐ Pace maker	☐ Emphysema	☐ Crohn's Disease	☐ Chronic pain
☐ Heart disease	☐ COPD		☐ Arthritis (RA or OA)
Neurological	**Other**	**Skin Conditions**	**Infections**
☐ Stroke	☐ Cancer	☐ Skin cancer	☐ Hepatitis type:
☐ MS	☐ Frequent Headaches	☐ Rosacea	☐ Tuberculosis
☐ ALS	☐ Concussions	☐ Chronic acne	☐ HIV/AIDS
☐ Parkinson's	☐ Diabetes type:	☐ Acne scaring	☐ Herpes
☐ Loss of sensation	☐ Epilepsy	☐ Spider veins	

What is your primary complaint?

When and how did it start?

Are you currently experiencing….

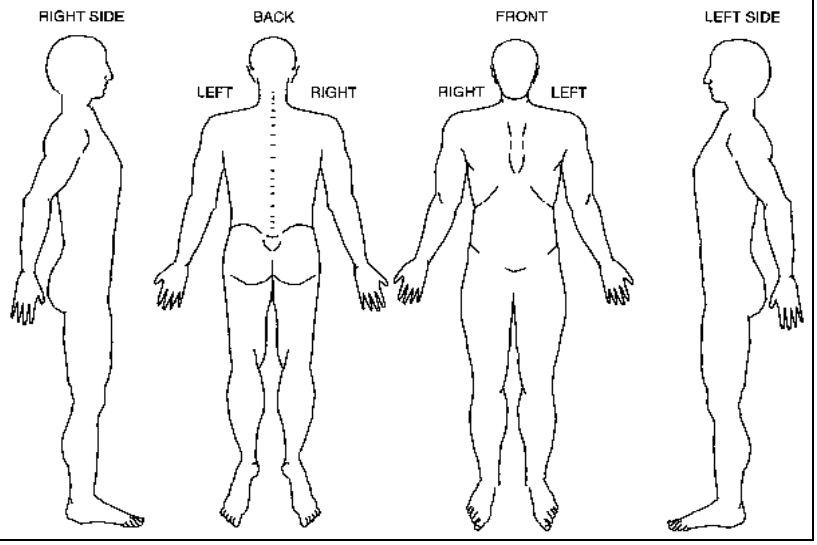
Pain: ☐ Yes☐ No (Dull, Sharp, Shooting)
Mark "P" for PAIN on the diagram.

Stiffness: ☐ Yes ☐ No (Muscle, Skin, Joint)
Mark "S" for STIFFNESS on the diagram.

Numbness:☐ Yes☐ No (Dull, Sharp, Shooting)
Mark "N" for NUMBNESS on the diagram.

Burning:☐ Yes☐ No
Mark "B" for BURNING on the diagram.

Immobility:☐ Yes☐ No
Mark "I" for IMMOBILITY on the diagram.



Cancellation Policy

A 24-Hour Cancellation Policy does apply to your consultation appointment times. Failure to provide 24-Hours notice will result in a **non-insurable full-service fee charge.**

Note: If you are unable to attend your scheduled appointment the practice will, depending upon availability, provide you with an alternative appointment to avoid a cancellation fee being charged.

Consent to Treatment for Massage Therapy

I have filled out a complete/updated Health History Form for Massage Therapy and have had an opportunity to ask any questions that I may have to clarify and better understand why an accurate Health History is needed begore massage begins. I understand that there are some very slight risks including but not limited to, muscle strains, bruising, light headed or dizziness and tenderness. I rely on the massage therapist to exercise judgment during the course of treatment towards my best interests.

I have read the above and give my consent to the Massage Therapist to proceed with assessment, treatment and/or exercise plan/ I intend this consent to cover the entire course of my treatment.

Signature (or Parent/Guardian): _____ Date: _____