KINETIC SPORTS THERAPY

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WWW.KINETICSPORTSTHERAPY.CA
905 818 5030

Health History / Intake

All information obtained in this form and through treatment is confidential and will not be shared
Unless your express authorization is given. Please feel free to ask any questions about the information being requested.

full name:		Telephone:	home
occupation:		Telephone:	business
address:	street / city		postal code
date of Birth:	Sex: M F	How did you hear about this clinic?	
e-mail address:		Your Doctor:	
emerg. contact:		➔ their number:	

Do you have or have you ever had:

cardiovascular condition	no	yes	high blood pressure	low blood pressure	heart disease	
			chronic congestive heart failure	phlebitis	cerebro-vascular accident	
			pacemaker or other similar device	myocardial infarction	other	
respiratory condition	no	yes	asthma	emphysema	shortness of breath	
			bronchitis	chronic cough	other	
surgery	no	yes	➔ what type?		➔ when?	
hospitalization	no	yes	➔ what type?		➔ when?	
a significant injury	no	yes	➔ why?		➔ when?	

menstrual problems	no	yes	general health:	good	fair	poor
are you pregnant	no	yes	urinary or bowel problems		no	yes
insomnia	no	yes	vision or hearing loss		no	yes
diabetes	no	yes	skin conditions		no	yes
epilepsy	no	yes	allergies or hypersensitivities		no	yes
arthritis	no	yes	allergies where the response is anaphylaxis or skin irritation		no	yes
cancer	no	yes	infectious conditions (such as TB, hepatitis, HIV, etc.)		no	yes

Have you ever been diagnosed with any other illness or dysfunction?

Presents of internal pins, wires, artificial joints or special equipment

List any current medications (prescription or patent):

What are your activities of daily living? (exercise, relaxation, hobbies, etc.)

List any other medical concerns: (e.g.: digestive conditions, gynecological conditions, hemophilia, etc.)

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What brings you in today?

Have you had massage / ART before?	no	yes
Are you receiving any other treatment?	no	yes

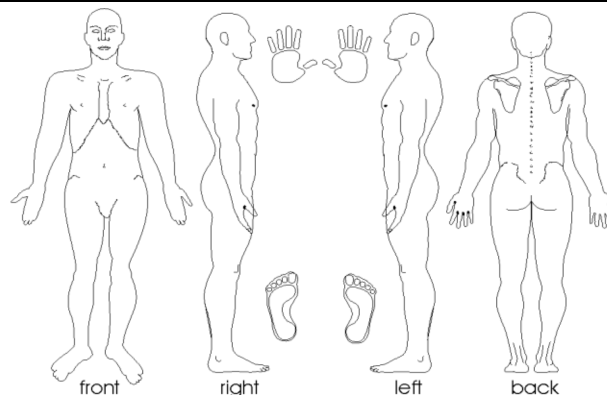
Specify other treatments:

What types of sensations are you experiencing?

sharp pain	aching	dull pain	general pain
numbness	tingling	stiffness	Shooting pain

Where are you experiencing problems?

muscles	joints	skin	other



Please mark troubled areas on this chart.

The above information is accurate and complete. I have read the policies on the back of this form.
I will notify the therapist of any changes to my health history in order to ensure the safest and most appropriate treatment.
I am aware that I may experience possible side effects such as muscle soreness for up to 24 to 48 hours after treatment.
I hereby consent to massage therapy treatment.

signature: date: day month year