KNOTS
Registered Massage Therapy

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info@knotsrmt.ca

Date	Month/Day/Year

Intake form - Patient information

GENERAL DETAILS

First Name	
Last Name	

Preferred Pronoun	He/His ☐	She/Hers ☐	They/Their ☐
Age		Date of Birth	YY/MM/DD

How did you hear about us?	Internet ☐	Facebook ☐	Instagram ☐	Twitter ☐	Word of Mouth ☐	Drove past clinic ☐	Roadside sign ☐

How much casual conversation are you comfortable with during your treatment?	No conversation ☐	Minimal conversation ☐	Moderate conversation ☐

CONTACT INFORMATION

Address			
City/Province		Postal code	

Phone (primary)	( )
Phone (other)	( )

Email address	
Occupation	
Emergency contact name	
Emergency contact phone	( )

GENERAL PRACTITIONER and SPECIALIST INFORMATION

GP Name	
Phone	( )
Address	
City/Province	

Are you currently seeing a medical specialist?	YES	NO
Specialist name		
Reason for specialist		

Pain and discomfort can be traced back to many different origins. To obtain a complete picture of your overall health, please complete this form. If you are having difficulty with any of the following, please check the box.

GENERAL
- ☐ Insomnia
- ☐ Fatigue
- ☐ Weight loss
- ☐ Weight gain

HEAD
- ☐ Headache
- ☐ Dizziness
- ☐ Head trauma
- ☐ Fainting
- ☐ Blacking out

EYES
- ☐ Itching/redness
- ☐ Change in vision
- ☐ Cataracts
- ☐ Light sensitivity
- ☐ Flashes in vision
- ☐ Spots in vision
- ☐ Glaucoma

EARS
- ☐ Ringing/tinnitus
- ☐ Impaired hearing
- ☐ Earache
- ☐ Dizziness
- ☐ Discharge

MOUTH & THROAT
- ☐ Bleeding gums
- ☐ Cold sores
- ☐ Sore throat
- ☐ Jaw/TMJ problems
- ☐ Hoarseness
- ☐ Swollen glands
- ☐ Goiter

NOSE
- ☐ Hayfever
- ☐ Loss of smell
- ☐ Nosebleeds
- ☐ Sinus problems

LUNGS
- ☐ Difficulty breathing
- ☐ Shortness of breath
- ☐ Persistent cough
- ☐ Coughing phlegm
- ☐ Coughing blood
- ☐ Asthma
- ☐ Pneumonia
- ☐ Emphysema
- ☐ Bronchitis
- ☐ Infections

VASCULAR
- ☐ Angina
- ☐ Murmers
- ☐ Heart disease
- ☐ Chest pain
- ☐ Palpitations
- ☐ Ankle swelling
- ☐ Cold feet/hands
- ☐ Leg cramps
- ☐ Calf pain
- ☐ Varicose veins
- ☐ Low blood pressure
- ☐ High blood pressure

GASTROINTESTINAL
- ☐ Bloating/gas
- ☐ Heartburn
- ☐ Ulcers
- ☐ Liver disease
- ☐ Gall bladder disease
- ☐ Vomiting/nausea
- ☐ Abdominal pain
- ☐ Diarrhea
- ☐ Constipation
- ☐ Blood in stool
- ☐ Hemorrhoids
- ☐ Hernias

URINARY
- ☐ Difficulty urinating
- ☐ Pain urinating
- ☐ Blood in urine
- ☐ Incontinence
- ☐ Bed-wetting
- ☐ Urinary urgency
- ☐ Frequent urination
- ☐ Frequent infections
- ☐ Kidney stones

NEUROLOGICAL
- ☐ Seizures/epilepsy
- ☐ Strokes
- ☐ Tingling sensation
- ☐ Numbness
- ☐ Muscle weakness
- ☐ Difficulty walking
- ☐ Poor coordination
- ☐ Paralysis
- ☐ Speech problems
- ☐ Loss of memory

MUSCLE & BONE
- ☐ Joint pain
- ☐ Swollen joints
- ☐ Stiffness
- ☐ Muscle ache
- ☐ Foot trouble
- ☐ Arthritis
- ☐ Bone pain
- ☐ Fractures
- ☐ Dislocations

SKIN
- ☐ Rash
- ☐ Itching/hives
- ☐ Changes in moles
- ☐ Acne
- ☐ Psoriasis
- ☐ Eczema

ENDOCRINE
- ☐ Diabetes
- ☐ Hypoglycemia
- ☐ Hormone therapy
- ☐ Thyroid problems
- ☐ Heat/cold intolerance
- ☐ Excessive thirst
- ☐ Excessive hunger
- ☐ Excessive sweating
- ☐ Night sweats

EMOTIONAL
- ☐ Depression
- ☐ Mood swings
- ☐ Anxiety/nervousness
- ☐ Tension
- ☐ Phobias
- ☐ Alcohol/drug abuse

CONDITIONS
- ☐ AIDS/HIV
- ☐ Eating disorders
- ☐ Heart condition
- ☐ Rheumatic arthritis
- ☐ Rheumatic fever
- ☐ Alcoholism
- ☐ Cancer/tumor
- ☐ Polio
- ☐ Parkinson’s
- ☐ Multiple sclerosis
- ☐ Gout
- ☐ Anemia
- ☐ Osteoporosis
- ☐ Osteoarthritis
- ☐ High cholesterol
- ☐ Fibromyalgia
- ☐ Chronic fatigue
- ☐ Hepatitis
- ☐ Migraines
- ☐ Contagious Blood diseases

HEALTH COMPLAINTS

Primary health complaint	
Other health complaints	
What would you like to gain from your visit? List two of your most important health goals	

MEDICAL HISTORY

Have you had previous care from any of the following practitioners?	☐ Massage therapist ☐ Chiropractor ☐ Naturopath ☐ Physiotherapist ☐ Acupuncturist ☐ Athletic therapist
Practitioner name	
Date	

Have you recently had any of the following procedures?	☐ X-Ray ☐ CT Scan ☐ MRI
Practitioner name	
Date	

List any surgeries, hospitalizations, motor vehicle accidents, or other accidents (with dates)	
List any medications or supplements you are currently taking, and why you are taking them	

What is your overall stress level?	
Reasons for stress	

How often do you exercise?	
What types of exercise do you perform?	

Do you smoke?	YES	NO
How many cigarettes/day?		
How long have you smoked for?		

WOMEN ONLY

Are you pregnant?	YES	NO	UN-SURE
Have you given birth?	YES	NO	
If yes, by:	Natural Delivery	Caesarean Section	