Nourished Health
335 Sheppard Ave. East
Toronto, ON, M2N 3B3
Tel: (647) 887-5040

Massage Therapy Initial Assessment Form

The information on this form will be kept confidential except as required by law. Your written permission will be required to release any information. **It is important to be accurate** so that we can ensure it is safe for you to receive a massage treatment. If your health status or contact information changes in the future, please let us know.

Name: _____ Date: _____

Mailing Address: _____ City: _____ Postal Code: _____

Email Address: _____ Date of Birth: dd_____/mm_____/yy_____

Telephone: (home) _____ (work) _____ (other) _____

Occupation: _____ What is your primary complaint? _____

Extended health care plan? ☐ Yes ☐ No

Referred by: _____

Please be specific: name of friend, name of doctor, advertisement location, website, etc.

Please indicate conditions you are experiencing, or have experienced in the past:

HEAD / NECK
- ☐ headaches
- ☐ vision problems / loss
- ☐ contact lenses
- ☐ earaches
- ☐ hearing problems
- ☐ jaw pain / TMJ disorder

RESPIRATORY
- ☐ chronic cough
- ☐ shortness of breath
- ☐ asthma –Date of last attack: _____
- ☐ bronchitis / emphysema
- ☐ smoking

CARDIOVASCULAR
- ☐ CCHF
- ☐ heart attack
- ☐ stroke / CVA
- ☐ pacemaker / similar device
- ☐ high blood pressure
- ☐ low blood pressure
- ☐ heart disease Type: _____
- ☐ poor circulation
- ☐ phlebitis
- ☐ varicose veins Dr. diagnosed? ☐yes ☐no

SKIN
- ☐ skin condition Type: _____
- ☐ bruise easily

INFECTIONS
- ☐ herpes
- ☐ hepatitis
- ☐ plantar warts
- ☐ rash / athlete's foot
- ☐ TB
- ☐ HIV / AIDS
- ☐ other: _____

OTHER CONDITIONS
- ☐ numbness & tingling Areas: _____
- ☐ difficult digestion
- ☐ constipation / diarrhea
- ☐ IBS
- ☐ liver: _____
- ☐ gallbladder: _____
- ☐ kidney: _____
- ☐ diabetes Onset: _____
- ☐ sinus: _____
- ☐ allergies (anaphylaxis or skin irritation): _____
- ☐ insomnia
- ☐ fatigue
- ☐ depression
- ☐ cancer: _____
- ☐ epilepsy –Date of last seizure: _____
- ☐ arthritis Dr. diagnosed? ☐yes ☐no Areas: _____
- ☐ menstrual problems / pain
- ☐ pregnancy –Due: _____
- ☐ menopausal problems: _____

OTHER MEDICAL CONDITIONS (including pins, wires, artificial joints or limbs, wheelchair, walker, cane, etc):

CURRENT MEDICATIONS
(including aspirin, herbs, vitamins, etc)

Name	Condition

Please turn over →

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Please list the timing & nature of ANY injuries, accidents and surgeries

Type:_____ Type:_____
Date:_____ Date:_____
Current symptoms:_____ Current symptoms:_____

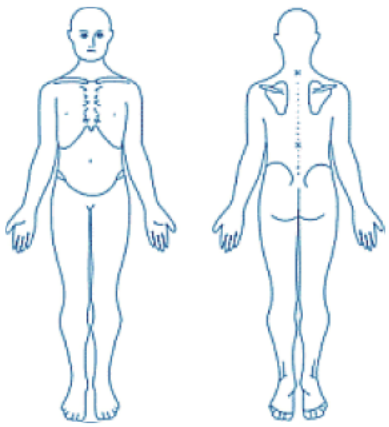
Type:_____ Type:_____
Date:_____ Date:_____
Current symptoms:_____ Current symptoms:_____

What is your primary complaint? _____

MUSCLES & JOINTS

Please indicate where you are currently experiencing pain or stiffness:

☐ neck / jaw: right / left
☐ shoulders: right / left
☐ arms: right / left
☐ hands: right / left
☐ mid back: right / left
☐ low back: right / left



☐ thighs: right / left
☐ knees: right / left
☐ lower legs: right / left
☐ ankles: right / left
☐ feet: right / left
☐ other: _____

OTHER HEALTH CARE

☐ massage therapy
☐ chiropractic
☐ physiotherapy
☐ psychotherapy

☐ acupuncture
☐ weekly exercise
☐ nutritional consultation
☐ other: _____

It is important for you to know that you may stop or modify your treatment at any time. Also, it is normal to experience side effects such as muscle achiness and tenderness for a period of up to 48 hours following your massage.

If an appointment is missed without 24 hours notice, you will be billed for the time booked.

Do you consent to receive treatment? ☐ Yes ☐ No

Signature:_____

THANK YOU for taking the time to accurately fill out this assessment form.

MEDICAL DOCTOR

Name: _____

Telephone: _____

Date of last visit: _____

Permission to send your Doctor a report pertaining to your health care? ☐yes ☐no