Vitality
Chiropractic & Laser Therapy Clinic

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Initial Registered Massage Therapy Consultation Form

Name: _____ **Initial Visit Date:** _____

DOB (M/D/Y): _____ **Care Card #:** _____

Address: _____ **City/Prov:** _____

Postal Code: _____ **E-mail:** _____

Phone #'s **H:** _____ **W:** _____ **C:** _____

Occupation: _____ **Benefit Provider(s):**_____

Is your visit today related to an ACTIVE workplace or motor vehicle injury? □Yes □No

Who may we thank for referring you? _____

As each patient's needs and goals are unique, so is our approach to patient management and treatment plan design. Which statement best describes the reason you sought the help of our Registered Massage Therapist?

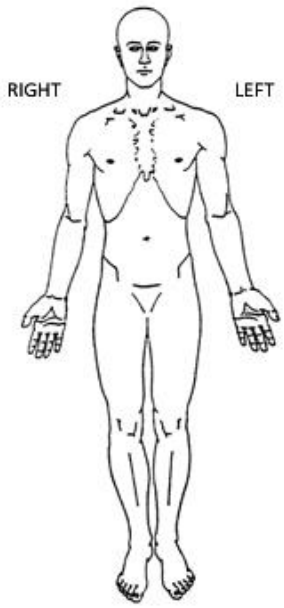
□ Diagnose my problem and help me through the initial steps of my recovery.

□ Assist me in getting to the point I can return to my work/activity/sport in some fashion.

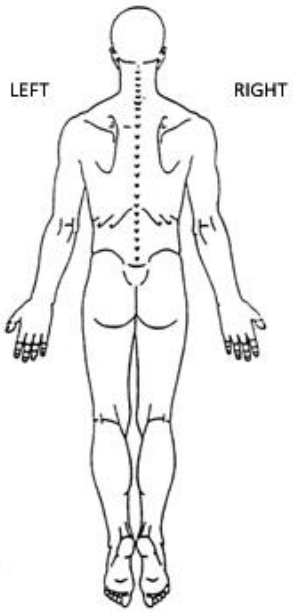
□ Support and guide me all the way to a complete and robust recovery.

□ Work with me on an ongoing basis in the pursuit of optimal wellness and injury prevention.

FRONT



BACK



Please indicate any painful or problem spots on the diagram with an '**X**'

Primary **COMPLAINT**: _____

How **LONG** have you had this problem?_____

How did it **START**? _____

Have you experienced this problem **BEFORE**?_____

What **AGGRAVATES** your condition? _____

What **RELIEVES** your condition? _____

Does your pain **TRAVEL** to other parts of your body?_____

Is the pain **CONSTANT**? ☐ Yes ☐ No How **INTENSE** is it at its worst? ___ /10 Is it **TRENDING**: ☐ Better ☐ Worse ☐ Same

Does your condition negatively **IMPACT** your: ☐ Work ☐ Sleep ☐ Sports ☐ Daily Tasks ☐ Mood ☐ Relationships

What **OTHER** health professionals have you seen for this condition? _____

What **TREATMENT** did you receive? _____ Was the treatment **HELPFUL**? ☐Yes ☐No

Have you ever had any prior **MASSAGE THERAPY** experience? ☐ Yes ☐ No Was this treatment **HELPFUL**? ☐ Yes ☐ No ☐ Somewhat

If you have had previous massage therapy experience, please describe the **TECHNIQUES** you are familiar with and whether they were helpful (i.e. deep tissue, myofascial release, relaxation) _____

Do you currently experience any of the following **NEUROLOGICAL** symptoms? Please check all which apply:

□ Dizziness/vertigo	□ Double vision	□ Loss of consciousness
□ Speech difficulties	□ Difficulty swallowing	□ Difficulty walking
□ Nausea	□ Lack of sensation/numbness	□ Confusion

Explain any of the checked items: _____

List **PREVIOUS** surgeries/accidents/major injuries: _____

_____

List current **MEDICATIONS**: _____

List your regular physical **EXERCISE**: _____

Are there any other **HEALTH** conditions, concerns, or diseases the massage therapist should be aware of (including pregnancy)?

_____

REGISTERED MASSAGE THERAPIST'S NOTES: