Elite
Sports Therapy

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Massage Therapy Patient Admittance Form

Name: ____
(last) (first) (initial)

Sex: ☐ Male ☐ Female Date of Birth: (mm/dd/yy) ____/____/_____ Height:________ Weight:______lbs

Home address: ____
(street) (city/province) (postal code)

Phone number: (______)____________________(______)____________________(______)____________________
Home Work Cell

Occupation/Employer: ____

In case of emergency, who should we notify/phone: ______________________________________

Relationship to you:______________________________Phone number:____________________

Name of primary health care practitioner: ____

Permission to consult with primary practitioner? Y N

Signature: ____ Date: __________________________

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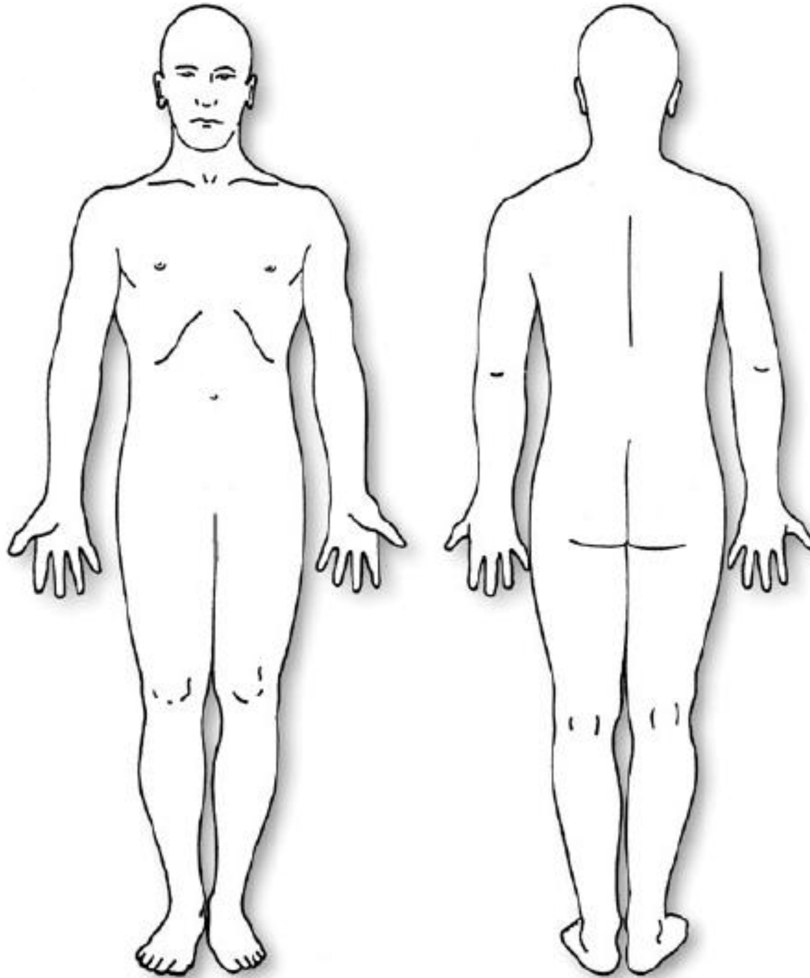
Pain Diagram



Please indicate the areas where you are feeling pain for discomfort, according to the following scale.

Sensation:	Indicate using a:
Sharp pain	S
Numbness/Tingling	N
Achy/Dull pain	A
Burning pain	B
Decreased sensation	↓
Increased sensation	↑
Other, please specify:	?

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General Systems Review

Please select any items that relate to your condition or body.

Respiratory
- □ Allergies
- □ Asthma
- □ Bronchitis
- □ Chest pain
- □ Cough
- □ Emphysema
- □ Frequent Colds
- □ Hay fever
- □ Pneumonia
- □ Smoker
- □ Tuberculosis

Hair
- □ Colour changes
- □ Recent loss

Ears
- □ Buzzing
- □ Discharges
- □ Infection
- □ Ringing
- □ Dizzy

Mouth/Throat
- □ Bleeding
- □ Hoarseness
- □ Difficulty swallowing
- □ Difficulty speaking
- □ Loss of taste

Vascular
- □ Anemia
- □ Discoloration
- □ Easy bleeding
- □ Easy bruising
- □ Hemorrhoids
- □ Cold hands/feet
- □ Leg pain after walking
- □ Raynaud's
- □ Swelling
- □ Thrombophlebitis
- □ Tranfusions
- □ Varicose veins

Skin
- □ Acne
- □ Boils
- □ Colour changes
- □ Dermatitis
- □ Eczema
- □ Fungal infection
- □ Dryness
- □ Goiter
- □ Herpetic infection
- □ Itching
- □ Lumps
- □ Pain
- □ Polyps
- □ Psoriasis
- □ Rashes
- □ Scars
- □ Shingles
- □ Skin Tags
- □ Steroid therapy
- □ Swelling

Musculoskeletal
- □ Arthritis
- □ Fractures
- □ Gout
- □ Hernia
- □ Back pain
- □ Neck pain
- □ Shoulder pain
- □ Elbow pain
- □ Wrist pain
- □ Hand pain
- □ Hip pain
- □ Knee pain
- □ Ankle pain
- □ Foot pain
- □ Muscle injury
- □ Stiffness
- □ Osteoarthritis
- □ Rheumatoid arthritis
- □ Tenderness
- □ Fibromyalgia
- □ Chronic fatigue
- □ Osteoporosis

Vision
- □ Redness
- □ Glaucoma
- □ Light Sensitivity
- □ Blurred vision
- □ Cataracts
- □ Double vision
- □ Dyslexia
- □ Tearing

Head
- □ Concussion
- □ Headaches
- □ Insomnia
- □ Itching
- □ Difficulty with memory
- □ Difficulty concentrating
- □ Mental illness
  Specify:

Urinary
- □ Bladder infection
- □ Kidney infection
- □ Blood in urine
- □ Bed wetting
- □ Burning
- □ Dribbling
- □ Hesitancy
- □ Incontinence
- □ Infection
- □ Kidney stone
- □ Nephritis
- □ Gall stones
- □ Yeast infection
- □ Decreased force of urine stream
- □ Decreased frequency of urination
- □ Increased frequency of urination

Sleep
- □ Disrupted

Cardiovascular
- □ Angina
- □ Ankle swelling
- □ Arrhythmias
- □ Arteriosclerosis
- □ Blood clots
- □ Chest pain
- □ Cold/blue hands, feet
- □ Low blood pressure
- □ Heart racing
- □ Shortness of breath
- □ Pounding sensation
- □ Heart attack
- □ Heart murmur
- □ Chronic heart failure

Gastro-intestinal
- □ Diarrhea
- □ Constipation
- □ Loss of appetite
- □ Black stool
- □ Bloody stool
- □ Difficulty with weight gain
- □ Chron's
- □ Colitis
- □ Foul smelling stool
- □ Heart burn
- □ Mucous in stool
- □ Nausea
- □ Pain
- □ Gall bladder problem
- □ Gas and bloating
- □ Irritable bowel syndrome
- □ Pain after eating
- □ Pain during eating
- □ Loss of appetite
- □ Stomach cramps
- □ Vomiting
- □ Ulcers
- □ Other digestive disorder

Specify:

Neurological
- ☐ Alzheimer's
- ☐ Burning
- ☐ Epilepsy
- ☐ Fainting
- ☐ Numbness
- ☐ Parkinson's
- ☐ Seizures
- ☐ Tingling
- ☐ Tremors
- ☐ Multiple sclerosis
- ☐ Other:

Endocrine
- ☐ Diabetes
- ☐ Hyperthyroid
- ☐ Hypothyroid
- ☐ Increased thirst
- ☐ Water retention
- ☐ Cold intolerance
- ☐ Heat intolerance
- ☐ Increased sweating

Female Reproductive
- ☐ Pregnant
- ☐ Birth control pills
- ☐ Irregular discharge
- ☐ HIV
- ☐ Hysterectomy
- ☐ Lumps
- ☐ Menopause
- ☐ PMS
- ☐ Irregular cycle
- ☐ Sores
- ☐ Uterine fibroids
- ☐ Spotting
- ☐ Fertility problems
- ☐ Increased flow
- ☐ Painful cycle
- ☐ Pelvic inflammation
- ☐ STD
- ☐ Decreased sex drive

Male reproductive
- ☐ Impotence
- ☐ Irregular discharge
- ☐ Rashes
- ☐ Testicular pain
- ☐ Prostate problems
- ☐ STD
- ☐ Decreased sex drive

Numbness or Tingling
- ☐ Shoulders
- ☐ Arms
- ☐ Hands
- ☐ Hips
- ☐ Groin
- ☐ Legs
- ☐ Feet
- ☐ Other:

Other
- ☐ Alcoholism
- ☐ Smoker
- ☐ Cancer
- ☐ Chemotherapy
- ☐ Depression
- ☐ Hepatitis
- ☐ Night sweats
- ☐ Steroid therapy
- ☐ Surgery
- ☐ Radiation therapy
- ☐ AIDS
- ☐ HIV
- ☐ Hospitalization
  Specify:
- ☐ Recent trauma
  Specify:
- ☐ Recent surgery
  Specify:

Family History
- ☐ Arthritis
- ☐ Genetic condition
  Specify:
- ☐ Auto-immune condition
  Specify:
- ☐ Cancer
- ☐ High blood pressure
- ☐ Diabetes
- ☐ High cholesterol
- ☐ Thyroid problems
- ☐ Heart disease
- ☐ Stroke
- ☐ Vascular condition
  Specify:

Childhood conditions
- ☐ Measles
- ☐ Mumps
- ☐ Chicken pox
- ☐ Whooping cough
- ☐ Scarlet fever
- ☐ Diphtheria
- ☐ Rheumatic fever
- ☐ Typhoid fever
- ☐ Ear infections
- ☐ Tubes in ears
- ☐ Asthma
- ☐ Allergies
- ☐ Hospitalizations:
  Specify:

Please list any current medications.

____

____

____

MASSAGE HISTORY

Have you ever received a professional massage? Y N

If so, date of last massage: ______________________

Reasons for consulting the clinic? ____
____
____

What do you want from your massage sessions? ____
____
____

Prioritize the areas of the body that you prefer to be massaged. ______________________________
____
____

CURRENT CONCERN

What is your current concern? ____
____

What was the onset? ____
____

Provide primary symptoms. Rate the symptoms as mild, moderate, or severe. ____________________
____
____

Are you currently under a medical practitioners care? Y N

If yes, provide the diagnosis and type of care you are receiving: ______________________________
____

OTHER

Accidents: ____

Surgeries: ____

Massage Therapy Waiver

WAIVER

I have stated all medical conditions that I am aware of and I will update my massage practitioner of any changes in my health status. I agree to immediately inform the therapist if I experience any pain or discomfort during my massage so that the pressure and/or strokes may be adjusted to my level of comfort. I assume all risks and responsibilities from any injury or liability that may occur as a result of this session.

Date: ____________________

Signature: ____________________________

FEE SCHEDULE

Massage Therapy

30 minutes	**$50.00**
60 minutes	**$80.00**
90 minutes	**$115.00**

Payment is due when services are rendered. **Twenty four (24) hours notice is required for cancellation of appointments**. If the required 24 hours notice is not provided, you may be charged for the full cost of your session.

Patients with extended health benefits must submit payment up-front, and then submit their receipts to their insurance company for reimbursement. The patient is responsible to check with their insurance company to determine if their treatment will be covered.

If this is an automobile accident case, every effort will be made to obtain payment from the insurance company, but in the event that the insurance company denies payment, the patient is responsible for the cost of any treatments to date.

If this is a WCB (Worker's Compensation Board) case, please note that *Elite Sports Therapy* is not a WCB authorized clinic. If you still wish to obtain treatment, you will be responsible for the cost of treatment, and you will be provided with a receipt. *Elite Sports Therapy* is not responsible if the fees are not reimbursed by WCB.

Signature: ____ Date: _________________________