māhāyā
Health Services

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RMT PATIENT INTAKE FORM

Name: _____ **Date of Birth:** _____ **Gender:** _____

Address: _____ **Phone Number:** _____

_____ **Email:** _____

Emergency Contact: _____ **Emerg. Phone Number:** _____

Physician's Name: _____ **Phys. Phone Number:** _____

Date of Last Physician Visit: _____ **Occupation:** _____

How did you learn about Mahaya? ☐ Mahaya Website Booking
☐ Google ☐ Facebook ☐ Yelp ☐ Open Care ☐ Friend of Mahaya ☐ Other _____

Would you like to recieve our newsletter? ❒ YES ❒ NO

Are you interested in recieving information about one of our *other holistic health practitioners*? If so, which ones?

❒ naturopathy ❒ psychotherapy ❒ acupuncture
❒ osteopathy ❒ holistic nutrition ❒ private yoga sessions

Have you had a massage before? Any comments about your previous massage experience?

_____
_____

Do you exercise regularly? What type and how often?

_____

Current Medications (including topicals, remedies, supplements)

drug name: _____ used for: _____
drug name: _____ used for: _____
drug name: _____ used for: _____
drug name: _____ used for: _____

Do you have or make use of any of the following?

❒ pacemaker ❒ medication patch ❒ chemo or drug port
❒ rods, pins, wires ❒ breast implants ❒ artificial joint(s) or limb(s)
❒ crutches ❒ cane/walker ❒ wheelchair

Are you receiving, or have you received, care from any of the following?

❒ physiotherapy ❒ psychotherapy ❒ naturopathy
❒ chiropractic ❒ medical specialist ❒ other: _____

Check any that apply :

RESPIRATORY

❒ bronchitis/chronic cough
❒ asthma
❒ emphysema
❒ other:

CARDIOVASCULAR

❒ high blood pressure
❒ low blood pressure
❒ angina
❒ heart attack
❒ congestive heart failure
❒ phlebitis
❒ poor circulation
❒ other: _____

CENTRAL NERVOUS SYSTEM

❒ epilepsy
❒ TIA/stroke
❒ multiple sclerosis
❒ parkinsonism
❒ other: _____

INFECTIOUS CONDITIONS

❒ hepatitis - type:
❒ HIV/AIDS
❒ tuberculosis
other: _____

SKIN

❒ infection
❒ warts, herpes
❒ eczema
❒ psoriasis
❒ other: _____

HEADACHES

type: _____
frequency: _____

MUSCULOSKELETAL

❒ neck problem
❒ shoulder problem
❒ arm problem
❒ wrist problem
❒ hand problem
❒ mid back problem
❒ low back problem
❒ hip problem
❒ knee problem
❒ ankle problem
❒ foot problem

DIABETES

❒ year diagnosed: type: _____
❒ current complications?

ALTERED SENSATION

❒ where? _____

ARTHRITIS

type: _____
where? _____

SURGERIES

type: _____ year: _____
type: _____ year: _____
type: _____ year: _____
type: _____ year: _____
current complications?
_____

INJURIES

type: _____ year: _____
type: _____ year: _____
type: _____ year: _____
type: _____ year: _____
current complications?
_____
_____

CANCER

❒ year diagnosed: type:
❒ chemotherapy
❒ radiation
❒ current complications?
_____

HEARING/VISION

❒ visual impairment - type: _____
❒ hearing impairment - type: _____

DIGESTION/URINATION

❒ constipation
❒ irritable bowel syndrome
❒ Crohn's disease
❒ kidney disease
❒ recurrent infection
❒ prostate problem
❒ other: _____

ALLERGIES

❒ nuts
❒ herbs
❒ oils, creams, lotions
❒ aromas, airborne
❒ latex
❒ drug allergy
❒ history of anaphylaxis
❒ other: _____

FEMALE

❒ pregnant? due date: _____
❒ high risk pregnancy
❒ menstruation issues
❒ menopause issues
❒ breast pain
❒ breastfeeding
❒ endometriosis
❒ other: _____

I attest that the health history information provided is accurate to the best of my knowledge.

Signature of Patient (or Guardian): _____ **Date:** _____