evoke
WELLNESS CENTRE

# Registered Massage Therapy
confidential intake form

Name _____ Date of Birth(mmm/dd/yyyy) _____

Address _____ City _____ Postal Code _____

Home Phone _____

Cell Phone _____

Email _____

*Set up your appointment reminders*
*Text reminders Y / N*
*Cell Provider_____*
*Email reminders Y / N*

Occupation _____ Employer _____

How did you hear about Evoke?_____

If you were referred to our office who can we thank? _____

**Do you have an open ICBC claim? ☐ Yes ☐ No Do you have an open WCB claim? ☐ Yes ☐ No**
If YES please provide the following:
Personal Health #_____
Adjustor's Name _____
Claim # _____

**Please indicate if you believe any of the following apply to you:**

**Pregnancy related conditions:**
_ currently pregnant? Due date:
_ recently given birth? Date:
_ gestational diabetes
_ pregnancy induced hypertension
_ preeclampsia/eclampsia/toxemia
_ risk of premature labor
_ decreased fetal movement
_ multiple gestation
_ bed rest, please elaborate:

_ other:_____

**Head & Neck:**
_ headaches
_ head injury
_ epilepsy/seizures
_ dizziness/fainting
_ other head & neck condition

**Digestive/Urogenital:**
_ hernia
_ irritable bowel/colitis
_ diarrhea/constipation
_ other digestive condition

**Cardiovascular:**
_ heart attack
_ high/low blood pressure
_ stroke/aneurysm
_ pacemaker
_ heart disease
_ other heart condition
_ varicose veins
_ hemophilia
_ thrombus
_ other circulatory condition

**Respiratory:**
_ asthma
_ bronchitis
_ shortness of breath
_ emphysema
_ pneumonia
_ other respiratory condition

**Skin Conditions:**
_ bruise/scar easily
_ fungal infections
_ herpes
_ other

**Neurological:**
_ numbness/tingling
_ multiple sclerosis
_ impaired sensation
_ sudden weakness
_ other neurological condition

**Other Conditions:**
_ thyroid disorders
_ diabetes
_ cancer
_ arthritis
_ vision loss
_ hearing loss
_ other

**Infectious Disease:**
_ hepatitis
_ HIV/AIDS
_other

**Any other medical conditions:**
_____
_____
_____

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Past surgeries, illnesses, accidents or relevant medical history _____
_____
_____

Please list any medications that you are presently taking and the reason for administration:

| | **Medication** | **Reason:** |
|---|---|---|
| - | | |
| - | | |
| - | | |
| - | | |

Allergies _____

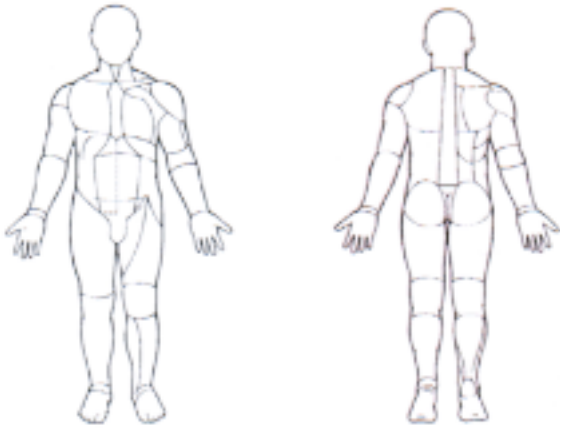
Are you currently receiving any other alternative care treatment? Please circle all that apply:
**Physiotherapy / Chiropractic / Registered Massage Therapy / Naturopathic / Acupuncture.**
Date of last visit?_____

Please describe your current condition & symptoms:

_____
_____
_____
_____
_____
_____
_____
_____
_____

Please indicate on the diagram the areas and nature of your symptoms using the appropriate symbols:

Dull & Aching: +++ Stiff & Tight: 222
Stabbing & Sharp: ooo Burning: XXX
Numbness: ----- Pins & Needles: ^^^



**Please Note:** Your appointment time has been reserved especially for you. In courtesy of your therapist we ask that you provide us with at least **24 hours notice** of cancellation or the full fee of your appointment will be charged. Payment for all treatments, whether private or insured, is ultimately the responsibility of the patient.

I have answered the above questions to the best of my ability and the information provided is current.
I authorize Evoke Wellness Centre and it's associated RMTs to collect my personal and medical information as documented in order to contact me and to provide a safe and appropriate treatment.
In addition, I authorize the clinic and it's associated therapists to communicate with my other health care professionals as deemed necessary for my beneficial treatment. I understand that my personal and medical information is confidential and will only be disclosed to third parties with my permission or as required by law.
I understand that Evoke Wellness Centre will maintain custody and control of my Health Care Records.

Today's date:_____ Signature:_____