Wetaskiwin
Family Chiropractic
Complete Lifestyle & Alternative Healthcare

Welcome

MASSAGE THERAPY PATIENT

Today's Date: _____ Name: _____
Date of Birth: mm/dd/yyyy _____ Age: _____ ☐ Male ☐ Female
Alberta Blue Cross ID Number: _____ Group Number: _____
Address: _____ City: _____ Province: _____
Postal Code: _____ E-mail: _____
Phone: (H) _____ (Bus/Cell) _____
Occupation: _____ Employer: _____
Emergency Contact (Name & Phone): _____

REASON FOR VISIT

How did you hear about our clinic? ☐ Phonebook ☐ Passing By ☐ Friend
☐ Relative ☐ Other _____

Describe your weekly exercise: _____
Please list any medications you are currently taking, including any supplements (multi-vitamins, calcium etc.): _____
_____

Please indicate if you have experienced any of the following conditions:

☐ Cancer	☐ Heart Disease	☐ High Blood Pressure
☐ Haemophelia	☐ Varicose Veins	☐ Diabetes
☐ Stroke	☐ Epilepsy	☐ Fibromyalgia

Any other conditions not listed: _____

Please check any of the following conditions that apply to you:

☐ Fainting/Dizziness	☐ Headaches	☐ Insomnia
☐ Chest Pain	☐ Muscle Ache	☐ Muscle Cramps
☐ Indigestion	☐ Constipation	☐ Swelling/Inflammation
☐ Arthritis	☐ Pins/Plates/Prosthesis	☐ Smoking (___/day)
☐ Pregnancy	☐ Contact Lenses	☐ Hernia
☐ Excessive Urination	☐ Skin Disorders	☐ Phlebitis
☐ Aneurysms	☐ Cold Hands/Feet	☐ Contagious Disease

Any other conditions not listed: _____
Any allergies, please list: _____

Injury & Symptom Description

Below, please list your major sypmtoms that you would like addressed during treatment:
1. _____
2. _____
3. _____

Was your condition the result of an accident? ☐ Auto ☐ Work ☐ Sports ☐ Other
When did the accident occur? _____
Please describe the accident or injury as fully as possible: _____
_____
_____
_____

ADDITIONAL HEALTH INFORMATION

PAIN DESCRIPTION

(please circle the appropriate descriptors for your specific area(s) of complaint)

	Pain Is	Pain Quality	Pain Severity	Pain Is Worse	Condition Began
NECK REGION	Constant Frequent Intermittent Occasional Worse on Right Worse on Left	Dull Burning Sharp Stiff Radiating	10 Severe 8 6 Moderate 4 2 0 None	Morning Evening During Activity Sitting Standing Wakes at night	

Please describe any trauma you have had to this area: _____

MID BACK REGION	Constant Frequent Intermittent Occasional Worse on Right Worse on Left	Dull Burning Sharp Stiff Radiating	10 Severe 8 6 Moderate 4 2 0 None	Morning Evening During Activity Sitting Standing Wakes at night	

Please describe any trauma you have had to this area: _____

LOW BACK REGION	Constant Frequent Intermittent Occasional Worse on Right Worse on Left	Dull Burning Sharp Stiff Radiating	10 8 6 4 2 0	Morning Evening During Activity Sitting Standing Wakes at night	

Please describe any trauma you have had to this area: _____

OTHER SPECIFIC AREA (please indicate) _____	Constant Frequent Intermittent Occasional Worse on Right Worse on Left	Dull Burning Sharp Stiff Radiating	10 8 6 4 2 0	Morning Evening During Activity Sitting Standing Wakes at night	

Please describe any trauma you have had to this area: _____

Describe briefly ANY treatments, tests performed and/or medications prescribed for these symptoms and the results:

Describe how these symptoms have affected your normal daily activities: _____

CONSENT FORM

Please read and answer all questions on this form. If you have any questions concerning this consent form, feel free to discuss these with the therapist. Please initial next to each paragraph that you have read and understood said paragraph. If you have any questions regarding the treatment, your therapist will discuss these with you.

Name: _____

Primary Caregiver (Chiropractic Dr., Medical Dr., Naturopath, etc.):

_____ Phone Number: _____

Name of referring professional or source: _____

_____ All information provided will be held in the **strictest confidence** unless upon receipt of a **written** request along with a signed release from the client. ALL or PART of the client's records can be released to the client, the client's personal representatives:

a) Lawyer; b) Insurance companies; c) other health care professional; d) others

_____ **Billing for a missed appointment will take place unless 24 hours prior notice is provided.** Payment for treatments is due upon completion of treatment. All fees are payable in Cash, with Cheque, Debit card, Visa or Mastercard.

Fees:	1 Hour Massage	$80.00 (plus GST)
	1/2 Hour Massage	$45.00 (plus GST)
	1 1/2 Hour Massage	$110.00 (plus GST)
	Cupping	$10.00 (plus GST)

_____ Draping defines the physical boundary between the client and therapist. Client privacy and respect will be assured at all times. The client may choose to be fully draped or clothed througout the treatment. Genitals, perineum and/or anus are **NEVER** undraped.

- A client has the right to refuse, modify or terminate treatment at any time.
- A therapist has the right to refuse, modify or stop treatment at any time if there is a resonable cause.

_____ I understand that massage therapy is given for the purpose of stress reduction, relief from muscular tension, spasm or pain or for increased circulation or energy flow. I understand that the therapist does not diagnose illness, disease or any other physical or mental disorder. It has been made clear to me that massage therapy is not a substitute for a medical examination or a diagnosis. It is recommended that I see a physician for any physical ailment that I might have. I also understand that if there are changes to my overall health, it is my responsibility to inform the therapist before future treatments.

I acknowledge that I have read and understood this consent and agree to its conditions.

Signature of Client: _____ Date: _____

Needs assessments, treatments, procedures, likely benefits and risks of treatments have been and will be discussed with the client.

Signature of Therapist: _____ Date: _____