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: ______________________________

____

	Pain Is	Pain Quality	Pain Severity	Pain Is Worse	Condition Began
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: ______________________________

____

	Pain Is	Pain Quality	Pain Severity	Pain Is Worse	Condition Began
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: ______________________________

____

	Pain Is	Pain Quality	Pain Severity	Pain Is Worse	Condition Began
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	$85.00 (plus GST)
	1/2 Hour Massage	$45.00 (plus GST)
	1 1/2 Hour Massage	$115.00 (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: ______________