Total Body Health Welcomes You!

Massage Therapy Intake

Legal First Name _____ Legal Last Name _____

Mailing Address _____ Postal Code _____

Home Phone _____ Cell _____ Work _____

Email Address _____ Newsletter Y ___ N ___

Date of Birth _____ M ____ F ____ Marital Status _____ No of Children ____

BC Health # _____ Extended Benefit Provider _____

Extended Benefit Plan/ID #'s _____

Relation to Plan Member _____ Date of Birth of Plan Member _____

Is this related to ICBC Motor Vehicle Accident Y ____ N ____ Claim # _____

Date of Accident _____ Are you receiving other treatment _____

Adjusters Name and Phone Number _____

Employer _____ Occupation _____

Referred by _____ Referred to _____

Emergency Contact _____

Family Doctor and Telephone # _____

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What is your main reason for coming in today?

_____

_____

Please descried your current condition and symptoms:

_____

_____

Have you seen a massage therapist before? Y ____ N ____

When and where was your last massage? _____

Health History

Circle all that apply

Heart Attack	High Blood Pressure	Low Blood Pressure
Stroke/Aneurysm	Pacemaker	Other Heart Conditions
Varicose Veins	Bruise Easily	Pregnancy
Diabetes	Kidney Disease	Other Urinary Condition
Hypoglycemia	Muscle Strain/Pain	Ligament Strain/Pain
Headaches/Migraines	Dizziness/Fainting	Nausea
Spinal Injury	Head Injury	Epilepsy/Seizures
Concussion	Asthma	Chronic Sinusitis
Other Respiratory Condition	Irritable Bowel/Colitis	Digestive Condition
Skin Condition	Depression	Anxiety
Joint Dislocation	Bone Fracture	Arthritis
Osteoporosis	Swollen Joints	Aching Joints
Rods/Pins/Plates/Shunts	Implants	Transplant
Corrective Lenses/Contacts	Cancer	HIV
Allergies		

Please list any other conditions or symptoms that are not listed above:

_____

_____

_____

_____

Please list any medications you presently take and for what condition:

_____

_____

_____

_____

Please list any hospitalizations, any major accidents, illnesses or surgeries:

_____

_____

_____

_____

Consents

Transactional Emails

You can opt to receive emails to keep you informed of new bookings, changes to your bookings, and reminders for upcoming appointments.

___ Email 2 days before appointment

___ Text Messages (SMS) 2 days before appointment

___ Text Messages (SMS) 2 hours before appointment

___ Phone Call 24 hours before appointment

News and Special Promotions

___ Yes, I would like to receive news and special promotions by email

Massage Therapy Consents

Consent for Treatment

I understand that there may be risks related to receiving a massage therapy treatment. I do not expect the therapist to be able to explain and treat all risks and complications, but I understand that they will treat me in the most safe and effective way that they can. I do not expect that massage therapy will cure my condition and is not a substitute for other medical modalities.

____ I consent to receive Massage Therapy

____ I do not consent

Assessment and Treatment

I understand that each appointment includes an interview, assessment, treatment, and patient education. Initial appointments may require longer interview and assessment times in order for the therapist to get a detailed medical history and evaluation. Longer assessment times may be needed depending on my current condition.

____ I agree

____ I disagree

Massage Therapy Fees

Registered Massage Therapy is covered by most extended health plans. Some benefit providers require a prescription and it is the patient's responsibility to check with their provider to ensure proper coverage. Missed appointment fees cannot be billed to extended benefits. We do not direct bill massage fees to WCB.

____ I understand

Cancellation Policy

Your appointment time is reserved just for you. In consideration of your fellow patients and practitioner, a minimum of 24 hours notice is required for any cancellations or changes to your appointment. Patients who provide less than 24 hours notice, or miss the appointment, will be charged a cancellation fee of 80% of the appointment fee.

____ I agree

Privacy and Sharing of Information

I authorize the clinic and its associated health professionals to collect my personal and medical information as documented above. In addition, I also understand that my personal and medical information is confidential and will only be disclosed to third parties with my permission.

____ I agree

____ I disagree

Patient Signature _____ Date _____