Balanced Health and Sports Therapy

Chiro ● Physio ● Massage

MASSAGE INTAKE AND RELEASE FORM

Personal Information: Date: _____

First Name: _____ Last Name: _____

Address: _____

City/Province: _____ Postal Code: _____

Telephone: Home: _____ Cell: _____

Work: _____ Alberta Health Care Number: _____

Date of Birth (DD/MM/YYYY): _____ Age: _____ Sex: _____

Occupation: _____

E-mail: _____ If you would like to receive our Newsletters filled with monthly promotions and articles on maintaining a healthy lifestyle, please place a check mark: ☐

Phone Call Reminders: ☐ Email Reminders: ☐ None: ☐

How did you hear about us? _____

Emergency Contact Information: Name: _____ Phone: _____

Will your care be covered by?

Private ins: ☐ Yes ☐ No **If Yes Who**: _____

Motor Vehicle Accident: ☐ Yes ☐ No **WCB:** ☐ Yes ☐ No **Veteran Affairs:** ☐ Yes ☐ No

How did you hear about the Balanced Health and Sports Therapy? _____

ARE YOU CURRENTLY TAKING MEDICATION: YES ☐ NO ☐

If **YES** LIST ALL MEDICATION(S): _____

WHAT CONDITION(S) ARE THE MEDIACATION(S) FOR: _____

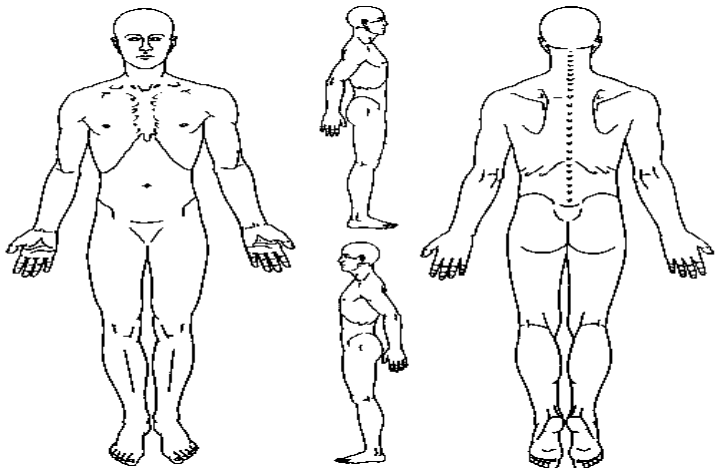
ARE YOU CURRENTLY RECEIVING CHIROPRACTIC CARE: YES ☐ NO ☐

IF YES WITH WHOM: _____

ARE YOU RECEIVING ANY OTHER THERAPIES OR TREATMENTS: YES ☐ NO ☐

IF YES PLEASE DESCRIBE: _____

MARK THE AREA(S) OF THE DIAGRAM WHERE YOU FEEL PAIN AND/OR DISCOMFORT.



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1519 – 19th Street NW, Calgary, AB T2N 2K2
Phone: (403) 282-0880 Fax: (403) 282-0898

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IF YOU ARE CURRENTLY EXPERIENCING OR HAVE EXPERIENCED ANY OF THE FOLLOWING, PLEASE CHECK:

☐ HIGH BLOOD PRESSURE
☐ LOW BLOOD PRESSURE
☐ HEART DISEASE
☐ CIRCULATORY PROBLEMS
☐ ARTHRITIS
☐ DIABETES
☐ JOINT PROBLEMS
☐ BURSITIS
☐ STRESS
☐ HEADACHES
☐ ALLERGIES
☐ BLOOD CLOTTING DISORDERS
☐ SKIN PROBLEMS
☐ ANY CONTAGIOUS DISEASES
☐ TMJ DYSFUNCTION
☐ BACK and/or NECK PAIN
☐ SEIZURES

Other Please List:
_____
_____
_____

ARE YOU PREGNANT: YES ☐ NO ☐

HOW OFTEN DO YOU EXERCISE? _____

ANY INJURIES, SURGERIES AND/OR MOTOR VEHICLE ACCIDENTS: YES ☐ NO ☐

WHEN:_____ DESCRIBE: _____

WHY HAVE YOU COME FOR MASSAGE? _____

PLEASE REMOVE ANY JEWELERY FROM THE AREA BEING MASSAGED. IF YOU WEAR CONTACT LENSES OR DENTURES IT IS RECOMMENDED THAT YOU REMOVE THEM FOR YOUR OWN COMFORT.

PLEASE READ THOUROUGHLY AND SIGN WHERE INDICATED BELOW

I UNDERSTAND THAT PAYMENT IS EXPECTED AT THE TIME OF VISIT.

Please note our cancellation policy: If less than 24 hours' notice is given to cancel your appointment, your account will be charged the full price of the appointment.

I UNDERSTAND THAT I WILL BE CHARGED THE FULL APPOINTMENT FEE ON ALL MISSED APPOINTMENTS OR CANCELLATIONS WITHOUT 24 HOURS NOTICE.

_____ _____
SIGNATURE of Patient (or parent/guardian) **DATE**

I UNDERSTAND THAT MASSAGE IS GIVEN HERE FOR THE PURPOSE OF STRESS REDUCTION, RELIEF FROM MUSCULAR TENSION, MUSCLE SPASM OR PAIN, AND/OR FOR INCREASING CIRCULATION.

I UNDERSTAND THAT THE MASSAGE THERAPIST DOES NOT DIAGNOSE ILLNESS, DISEASE OR ANY OTHER PHYSICAL OR MENTAL DISORDER. AS SUCH, THE MASSAGE THERAPIST DOES NOT PRESCRIBE MEDICAL TREATMENT OR PHARMECEUTICAL TREATMENT, NOR DO THEY PERFORM MANIPULATIONS. IT HAS BEEN MADE CLEAR TO ME THAT MASSAGE IS NOT A SUBSTITUTE FOR MEDICAL EXAMINATION OR DIAGNOSES.

I HAVE STATED ALL MY KNOWN MEDICAL CONDITIONS AND TAKE IT UPON MYSELF TO KEEP THE MASSAGE THERAPIST UPDATED ON MY PHYSICAL HEALTH.

_____ _____
SIGNATURE of Patient (or parent/guardian) **DATE**

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