FULL MOTION Health & pain management

**Phone: (403) 282-5590**
**Fax: (403)282-3877**

**#1766, 1632 – 14th Avenue NW**
**Calgary, Alberta T2N 1M7**

# Massage Intake Form

Name: _____ Date: _____

Address: _____

City, Province: _____ Postal Code: _____

Phone Number: (H) _____ (W) _____ (C) _____

Date of Birth (mm/dd/yyyy) _____ Gender: ( ) Female ( ) Male

Email: _____ Occupation: _____

Extended Health Insurance Company: _____ Policy/ ID # _____

Insured Member / Spouse / Child Name: _____Group/Ref#_____

**Emergency Contact**

Name: _____

Phone Number: (H) _____ (W) _____

**Who may we thank for the referral? □ Full Motion Website □ Yellow Pages (Book / Internet) □Direct-bill Website □ Mall / Walk In**

**□ Family / Friend Name** _____ **□Other** _____

What goal do you hope to attain with care? Pain relief / Relaxation _____

Correction of problem _____

Preventative care _____

Is this injury the result of a **motor vehicle accident**: Yes No If yes, please ensure the treating Therapist is informed to ensure the appropriate paper work is completed by Reception.

Is this injury the result of a **work related accident**: Yes No If yes, has **WCB** been notified: Yes No

Are you taking any medications, vitamins, herbs, or using essential oils?

| Medication, etc.: | Reason for Medication | Dosage: | How Long: |
|---|---|---|---|
| _____ | _____ | _____ | _____ |
| _____ | _____ | _____ | _____ |
| _____ | _____ | _____ | _____ |

Briefly list any **surgeries** you have undergone, for what and when:

_____

_____

Have you ever had a **lymph node** removed or radiated? □ Yes □ No

Do you have any internal wires, pins, plates, artificial joints or special equipment we should be aware of? □ Yes □ No

_____

Have you ever received a therapeutic massage? □ Yes □ No

_____

What would your rate your stress level at? low 1 2 3 4 5 6 7 8 9 10 high
(include all areas of your life such as work, relationships, physical health, finances)

General History continues on next page…..

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Name: _____ Date: _____

Please **check** if you are presently experiencing, or **circle** if you have experienced in the past:

**Cardiovascular:**
□ High blood pressure : _____
□ Low blood pressure: _____
□ Chronic congestive heart failure
□ Stroke/ CVA
□ Phlebitis/ Varicose Veins
□ Pacemaker
□ Heart disease
□ Bleeding disorder
□ Seizures
Family history of the above?
□ Yes □ No

**Head and Neck:**
□ History of headaches
□ History of migraine
□ Vision problems/ loss
□ Hearing loss
□ Tinnitus
□ Dizziness/Vertigo

**Respiratory:**
□ Asthma
□ Bronchitis
□ Emphysema
□ Chronic Cough
□ Smoking: _____

**GI conditions:**
□ Constipation
□ Diarrhea
□ IBS: _____
□ Crohn's Disease/ Colitis
□ Ulcers

**Infectious conditions:**
□ Conjunctivitis
□ Skin: _____
□ Hepatitis: _____
□ HIV
□TB
□ Athletes Foot
□ Plantar's Warts

**Other conditions:**
□ Bursitis
□ Psoriasis
□ Rash/eczema
□ Allergies: _____
□ Loss of sensation:
where: _____
□ Diabetes
type: _____
□ Epilepsy
□ Cancer
type/area: _____
□ Arthritis
type/area: _____
□ Fibromyalgia
□ Chronic Fatigue Synd.
□ Polio/Post Polio
□ Osteoporosis
□ Parkinson's
□ Multiple Sclerosis

□ **Recent Tattoos, Injections, IMS Needling**
type/area**:** _____
_____
_____

**Women Only:**
□ PMS
□ Menstrual cramping
□ Pregnancy
Due Date: _____
□ Previous pregnancy complications:
_____

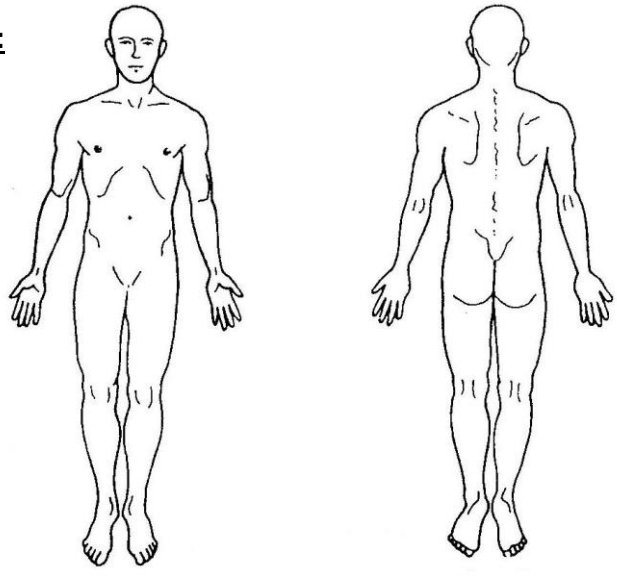
**Any Condition not listed:**
_____
_____
_____
_____

Areas of Discomfort or Concern?: _____

Please **CIRCLE** all the area(s) where you feel your pain or discomfort

**Muscle/joint pain or discomfort:**

□ Neck
□ Back: lower middle upper
□ Shoulders
□ Elbow
□ Wrist
□ Hand
□ Hip
□ Knee
□ Foot
□ Ankle



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# Financial Policy

1. Payment in CASH, DEBIT, VISA OR MASTERCARD is required at the time service is rendered, unless other arrangements have been made in advance.

2. Many private insurance companies provide full or partial coverage of Massage claims. These additional policies are between you and your insurance company. You can be assured that we will help fill out your claim accurately and as quickly as possible to assure you maximum benefits. We ask, however that you keep your account with us up to date.

Students (full-time, under 25) / seniors (65 years and older) reduced rates apply for certain services. Please inquire.

*For further information on fees and rates for additional services provided by the chiropractic office please speak with the chiropractor or administrative assistant, they will be happy to answer all your billing questions.*

## PLEASE READ AND SIGN BELOW

**I understand and agree that I am responsible for payment at the time of service unless previous arrangements have been made with the clinic. I also understand and agree that my private health insurance will be directly billed (if registered with Clinic) for services and that I have to send in my claims for reimbursement if direct billing is not possible, unless I am involved in a MOTOR VEHICLE ACCIDENT (MVA).**

**Name:** _____ **Signature:** _____

## CANCELLATION POLICY

**Please note that the clinic** cancellation policy requires 24 hours notice for all cancellations**. This is to ensure that patients who require care can be accommodated as quickly as possible. Your care is important to us, extraneous circumstances are understandable and will be accommodated accordingly; otherwise please call our office in advance to reschedule your appointment. Please note**, all missed appointments with less than 24 hours notice will be charged cancellation fee **regardless of any other reduced rates. This is payable by the patient and is not reimbursable by insurance.**

**Signature:** _____ **Reminder Calls Via:**_____
**(or E-mails)**

## CONSENT TO MASSAGE THERAPY

I understand and accept that massage is given here for the purpose of stress reduction; for relief from muscular tension, spasm, or pain; or for improving circulation or energy flow.
I understand and accept that the massage therapist does not diagnose illness, disease, or any other physical or mental disorder.
The massage therapist will not prescribe medical or pharmaceutical treatment, nor do they perform spinal manipulations. It has been made clear to me and I understand that massage is not a substitute for a medical examination or diagnosis and it is recommended that I see a Chiropractic or Medical Physician for any physical ailments I may have.
**I have informed the massage therapist of all my known medical conditions and take it upon myself to keep the massage therapist updated on my physical health and any changes to it**. I declare the information provided by me on this form to be true and correct in all respects. I understand that the massage therapist will rely on the information that I gave to him/her. I understand and accept any risks associated with omission or incorrect information provided with respect to my health.

**Client Signature:**_____ **Date:**_____
**Legal Guardian Signature (if under 18)**_____ **CLINIC WITNESS:**_____