

# 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: \_\_\_\_\_

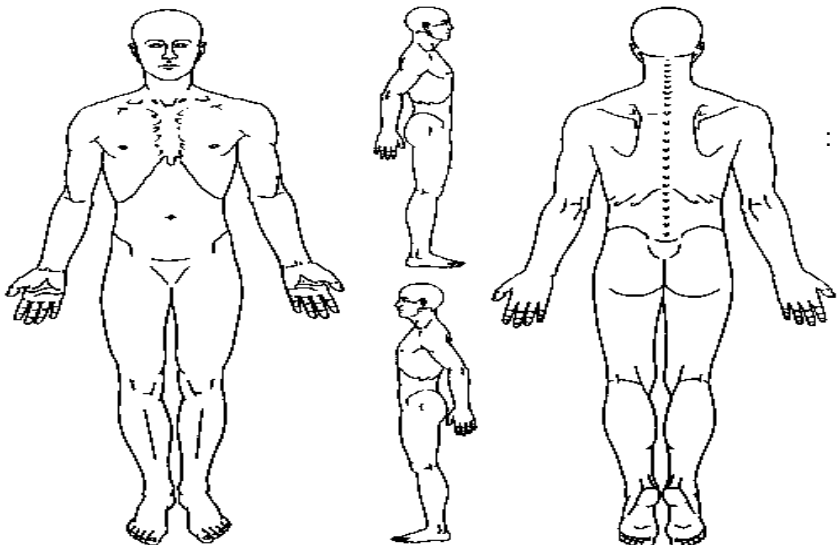
ARE YOU CURRENTLY RECEIVING CHIROPRACTIC CARE: YES  NO

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

- |   |   |                                   |
|---|---|-----------------------------------|
| <input type="checkbox"/> HIGH BLOOD PRESSURE  | <input type="checkbox"/> STRESS                   | <input type="checkbox"/> SEIZURES |
| <input type="checkbox"/> LOW BLOOD PRESSURE   | <input type="checkbox"/> HEADACHES                | Other Please List: _____          |
| <input type="checkbox"/> HEART DISEASE        | <input type="checkbox"/> ALLERGIES                | _____                             |
| <input type="checkbox"/> CIRCULATORY PROBLEMS | <input type="checkbox"/> BLOOD CLOTTING DISORDERS | _____                             |
| <input type="checkbox"/> ARTHRITIS            | <input type="checkbox"/> SKIN PROBLEMS            |                                   |
| <input type="checkbox"/> DIABETES             | <input type="checkbox"/> ANY CONTAGIOUS DISEASES  |                                   |
| <input type="checkbox"/> JOINT PROBLEMS       | <input type="checkbox"/> TMJ DYSFUNCTION          |                                   |
| <input type="checkbox"/> BURSTITIS            | <input type="checkbox"/> BACK and/or NECK PAIN    |                                   |

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 JEWELRY 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 THOROUGHLY 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 MESSAGE THERAPIST DOES NOT DIAGNOSE ILLNESS, DISEASE OR ANY OTHER PHYSICAL OR MENTAL DISORDER. AS SUCH, THE MESSAGE THERAPIST DOES NOT PRESCRIBE MEDICAL TREATMENT OR PHARMECEUTICAL TREATMENT, NOR DO THEY PERFORM MANIPULATIONS. IT HAS BEEN MADE CLEAR TO ME THAT MESSAGE 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 MESSAGE THERAPIST UPDATED ON MY PHYSICAL HEALTH.

\_\_\_\_\_  
**SIGNATURE of Patient (or parent/guardian)**

\_\_\_\_\_  
**DATE**