



Massage Therapy

Welcome to DOWNTOWN INTEGRATIVE HEALTH GROUP and thank you for the opportunity to help you with your health. To assist us in providing you with the best possible care, please fill out the following questionnaire accurately and thoroughly.

PERSONAL INFORMATION

Name _____ Date _____

Address _____

City, Province _____ Postal Code _____

Phone: Home _____ Business _____ Cell _____

E-mail _____ Alberta Health Card Number _____ - _____

Date of Birth (D/M/Y) _____ Age _____ Male [] Female []

Occupation _____ Employer _____

Contact Person _____ Their phone number _____

Do you have extended health care benefits? Yes No With whom? _____

Is this a WBC injury? Yes No

Are your injuries related to a Motor Vehicle Accident? Yes No

We appreciate those who refer their friends and family to our office. Please let us know who referred you to our care. Name _____ Relationship to you _____

If you weren't referred, how did you hear about us? M.D. Website Sign Phone Book

Other _____

**Although our office does not direct bill third party insurance coverage, we do encourage our patients to check their benefit package regarding their coverage for the following services: chiropractic, naturopathy, TCM, acupuncture, massage therapy, orthotics, exercise therapy. We will issue you receipts that you can submit for reimbursement.*

CURRENT HEALTH CONCERNS

What are the most important health concerns for which you are seeking treatment from us or are receiving elsewhere?

List in order of importance to you.

1. _____

2. _____

3. _____

What do you hope to gain from your treatment here? Check all that apply:

Pain reduction Return of function Guidance in future Prevention Other: _____

Health Providers *Who else have you seen regarding your health and when was your last visit?*

- | | |
|---|--|
| <input type="checkbox"/> Chiropractor | <input type="checkbox"/> Naturopathic Doctor |
| <input type="checkbox"/> Medical Doctor | <input type="checkbox"/> Dentist |
| <input type="checkbox"/> Physical Therapist | <input type="checkbox"/> Acupuncturist |
| <input type="checkbox"/> Massage Therapist | <input type="checkbox"/> Homeopath |
| <input type="checkbox"/> Traditional Chinese Medical Practitioner | <input type="checkbox"/> other |

Last Visit _____ Name of your Medical Doctor: _____ Please list any prescription and non-prescription medications, vitamins and other supplements, the dosage and reason for using them.

1. _____
2. _____
3. _____

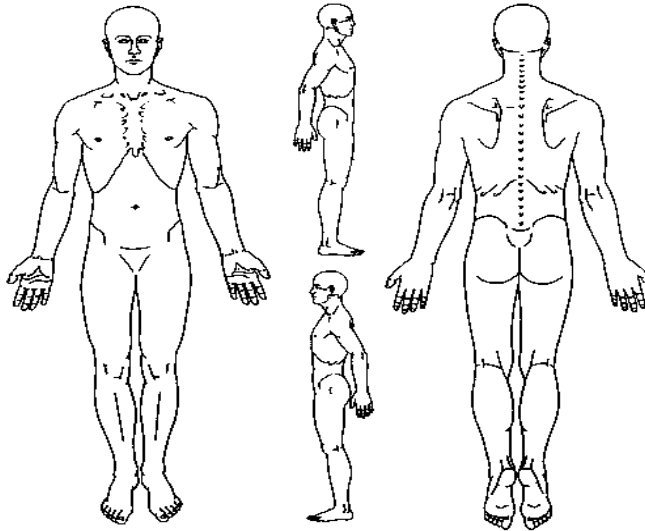
Please list any serious illnesses, surgeries, auto or sports injuries or broken bones _____ when _____

Have you reached full recovery? Yes No _____ when _____

Have you reached full recovery? Yes No _____ when _____

Have you reached full recovery? Yes No

On the diagram(s) below, please circle the area(s) that applies most to where you experience symptoms or feel pain.



Use these letters to describe the pain: **S** sharp **D** dull **A** achy **H** hot **C** cold **N** numb **T** tingling **DB** deep and boring **TW** twisting **V** variable

Is the condition getting progressively worse? Yes No

Is your condition: Constant Intermittent

Is this condition interfering with your: Work Sleep Daily routine Other _____



IMPORTANT INFORMATION FOR MASSAGE PATIENTS

Informed Consent to Treatment

I understand that the massage I will receive at this clinic is for the purposes of managing stress, relaxing my muscles, relieving tension and pain, and increasing circulation and energy flow. Their treatment will not include drugs or needles.

I understand that the massage therapist will not be diagnosing my problem, but will provide me with information that will direct me to an appropriate health care provider.

I will inform my therapist of all my known health problems and will provide updates on any changes in my health.

In a few cases unpleasant after effects may occur. These could include muscle soreness, stiffness, headache or nausea and will be temporary in nature. The therapist will advise me on ways of minimizing this possibility.

I have had an opportunity to review this with the therapist, and have had all questions answered to my satisfaction. I hereby consent to treatment.

Cancellation policy for massage appointments

Our massage therapists are independent contractors and are not paid by the clinic for the massage services they provide. The cost of your massage therapy is based on the length of your scheduled treatment time with a particular therapist.

If an appointment is made but not kept, it affects not only the therapist but also other patients who could have used that same time. Please respect their valuable time by keeping your appointments.

YOU WILL BE CHARGED FOR MISSED APPOINTMENTS UNLESS THE FOLLOWING OCCURS:

- YOU CALL AT LEAST 24 HOURS IN ADVANCE OF YOUR APPOINTMENT
- YOUR APPOINTMENT TIME CAN BE FILLED BY ANOTHER PERSON
- AN UNFORESEEN AND UNAVOIDABLE EMERGENCY OCCURS

Please note that insurance companies cannot be billed for missed appointments.

If you are scheduled for a one hour massage but arrive late you will be charged for the full amount of time that was scheduled. Please arrive early to prepare yourself for your massage. If you have any questions or comments please direct them to your massage therapist.

RELAX AND ENJOY

Patient/Guardian Signature

Date

