NORTHVIEW MASSAGE THERAPY CLINIC LTD.
INTAKE FORM

DATE: _____

Please take a moment to fill out this intake form.

CARE CARD#: _____

NAME: _____

ADDRESS: _____ POSTAL CODE: _____

CITY: _____ TEL: HOME #: _____

EMAIL: _____ WORK #: _____

DATE OF BIRTH: _____ OTHER #: _____

OCCUPATION _____ FAMILY DOCTOR: _____

If this is an **ICBC / WCB** (please circle) claim, provide:

CLAIM #: _____ DATE OF INCIDENT: _____

ADJUSTOR NAME: _____ PHONE#: _____ FAX#: _____

LOCATION OF CLAIM CENTER: _____

DOCTOR REFERRAL: _____ DATE OF DOCTOR'S REFERRAL: _____

Where did you hear about us? _____

What condition or area would you like treated? _____

How would you rate your current pain level?

0 1 2 3 4 5

slight moderate severe

Medications:

- ☐ Pain reliever
- ☐ Anti-inflammatory
- ☐ Muscle Relaxants
- ☐ HRT
- ☐ Heart / Blood Pressure
- ☐ Other: _____

Please list all allergies: _____

Are you currently receiving regular treatments from any of the following?

Chiropractor RMT Physiotherapist Naturopath TCM Acupuncturist

Please list with dates any serious accidents (ie: car accidents), surgeries, injuries, illnesses, conditions, or health issues: _____

_____

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Please circle any of the conditions below that are applicable to you:

Daily headaches
Migraines
Tinnitus
Jaw Pain
Muscle spasms

High stress levels
Chronic depression
Anxiety attacks

Contagious disease
HIV positive
Hepatitis
Skin condition

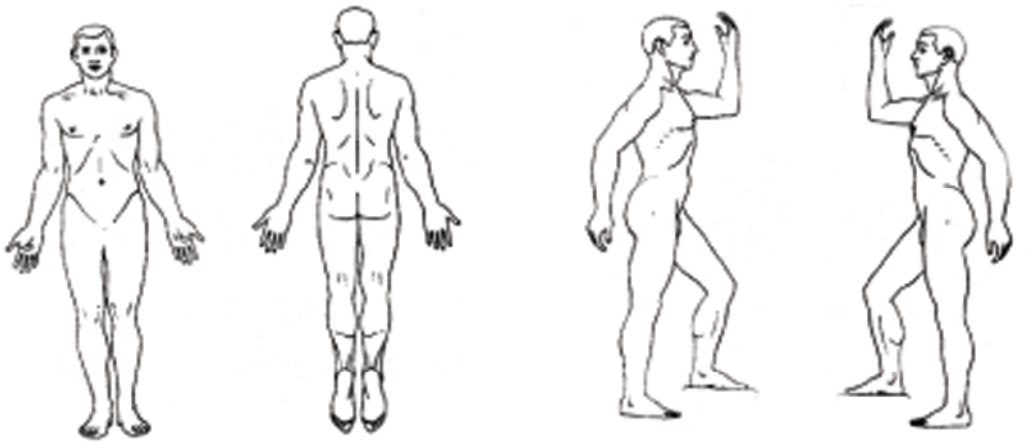
Patterns of Numbness/Tingling
Loss of Strength
Disc problem
Sciatica
Arthritis
Osteoporosis

Breathing difficulties
Asthma
Bronchitis
Sinusitis
Cancer
Epilepsy
Hemophilia
MS

Pregnancy ____wks
Diabetes
Digestive problems
Insomnia
Fever present

Heart condition
High or Low BP
Dizziness or Fainting
Varicose veins
Thrombosis

Please shade in area of pain:



NORTHVIEW MASSAGE
THERAPY CLINIC LTD.

INTAKE FORM

I, hereby give Northview Massage Clinic my consent to release/obtain information from the following individuals with respect to my care:

Physician(s)	_____	_____ Initials
Insurer	_____	_____ Initials
Employer	_____	_____ Initials
Other (list)	_____	_____ Initials

Cancellation Policy: In consideration of your fellow patients and your therapist a MINIMUM OF 24 HRS NOTICE is required to change or cancel your appointment. We regret that we must impose a charge for missed appointments equal to 50% of the treatment fee.

By signing this form, you consent to the RMT's at Northview Massage Therapy Clinic providing you with massage therapy treatments. We do not accept any liability for any claim as to the treatment or any complaint related to supposed conditions arising therby.

Signature: _____

Date: _____