INTAKEFORM

DATE: ____________________

Please take a moment to fill out this intake form.

CARE CARD#: ____________________

NAME: ____________________

ADDRESS: ____________________

CITY: ____________________

EMAIL: ____________________

DATE OF BIRTH: ____________________

OCCUPATION ____________________

POSTAL CODE: ____________________

TEL: HOME #: ____________________

WORK #: ____________________

OTHER #: ____________________

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?

☐ Internet ☐ Building Signage ☐ Phone Book ☐ Brochure

☐ Friend ____________________

☐ Work Colleague ____________________

☐ Medical Doctor ____________________

☐ Family Member ____________________

☐ Massage Therapist ____________________

☐ Physiotherapist ____________________

☐ Chiropractor ____________________

☐ BNI ____________________

☐ Other ____________________

Do you have Extended Healthcare Benefits? If yes, please add insurance name/policy/group plan/ID

____

What condition or area would you like treated? ____________________

Medications:

☐ Pain reliever ☐ Muscle Relaxants ☐ Heart / Blood Pressure

☐ Anti-inflammatory ☐ HRT ☐ Other:

Please list all allergies: ____________________

How would you rate your current pain level?

0	1	2	3	4	5
slight		moderate			severe

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: ____________________

____

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

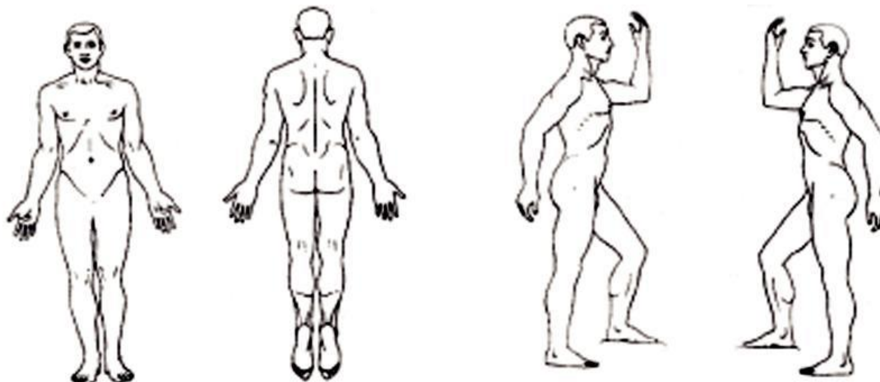
Patterns of Numbness/Tingling
Loss of Strength
Disc problem
Sciatica
Arthritis
Osteoporosis

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:



INTAKEFORM

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 100 % 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 thereby.

Signature: ______________________

Date: _________________