MASSAGE THERAPY INTAKE FORM

Today's Date: ____________________

STONEBRIDGE
— CHIROPRACTIC —

PERSONAL INFORMATION: **PLEASE PRINT CLEARLY**

Name (first/last): ____ Middle Initial: _____ Sex: __________

Preferred Name: ____

Date of Birth: _________________ Age: _____________ Sask Health Card #: ___________________________

Address: ____ City: _______________________________________

Prov: ____________ Postal Code: ___________________ Email: _____________________________________

Cell #: _______________________ Home #: _____________________ Work #: _________________________

Occupation: _____________________________________ Employer:_________________________________

Family Doctor: _______________________ Parent/Guardian Name (if under 18): _______________________

Emergency Contact (Name & Phone #): ____

Referred By: ________________________________ Referred To: _____________________________________

You can opt to receive emails/texts to keep you informed of new bookings, changes to existing appointments and reminders for upcoming appointments. Please initial the communication you would like to receive:

_____ Emailed notification of new bookings/changes to appointments

_____ Emailed reminders 24 hours prior to appointments

_____ Text reminders 24 hours prior to appointments

_____ Please do not send me any emails/text messages

Massage Depth Preference: (circle one): Light / Standard / Deep Tissue

Conversation During Treatment (circle one): None / Only Pertaining to Condition / All Conversation Welcome

LATE CANCELLATION/MISSED APPOINTMENT POLICY: As a courtesy to other clients, Chiropractors, and other providers, I understand that I must give at least **24 hours' notice** for cancellations or changes to my scheduled appointment. Stonebridge Chiropractic will charge me for **missed appointments or late cancellations at the rate of the scheduled visit, billed directly to me**, and is payable prior to my next visit. SGI, WCB and other insurers do not cover the cost of missed appointments. Please help us serve you better by keeping scheduled appointments. __________ **(Initial)**

INSURANCE POLICY: I am aware that it is my responsibility to check with my insurance company and its policies regarding provider and therapist requirements before receiving treatments from any provider at Stonebridge Chiropractic. Stonebridge Chiropractic is not responsible for any treatments not covered by my insurance. **I have read, understood, and agree to the above financial policies.** __________ **(Initial)**

Patient Signature: ____ **Date:** ______________________

PLEASE CONTINUE ON OTHER SIDE →

MEDICAL INFORMATION:

Have you been to a Massage Therapist before? (please circle) Yes / No

Reason for today's treatment: ____

Current medications/for what condition? ____

Did the current injury result from a motor vehicle accident or workplace injury? (please circle) Yes / No

Are you currently pregnant? Yes / No If yes, weeks? _____________

Are you under medical care for any of the following? (circle all that apply)

Anxiety/ Depression	High/Low Blood Pressure	Rheumatoid Arthritis
Back Injury	Jaw or Ear Pain	Skin Conditions
Cancer	Kidney Disease	Sleep Disturbances
Crohn's Disease	Neck Injury	Varicose Veins
Diabetes	Nervous Disorders	Whiplash
Epilepsy	Osteoarthritis	Autoimmune: _______________
Fainting or Dizziness	Osteoporosis	Other: _____________________
Headaches or Migraines	Pelvic Inflammatory Disease	
Heart Conditions	Phlebitis/Circulatory Problems	

Have you had surgery in the past? Yes / No

If yes, date and type: ____

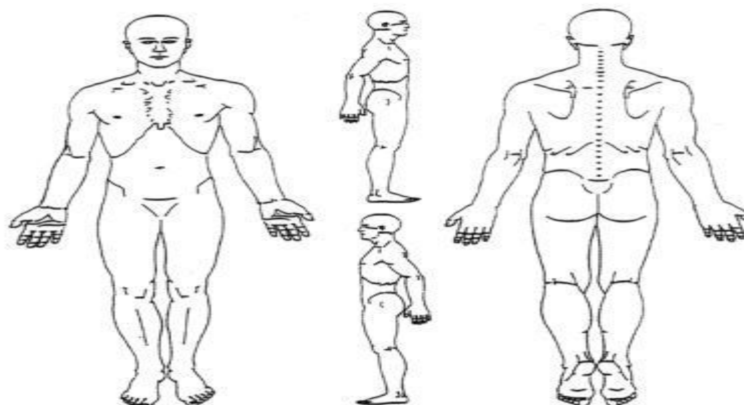
Have you had any serious illnesses in the past? Yes / No

If yes, please describe: ____

Have you had any of the following regarding your current condition? (circle all that apply)

Physician's examination / X-ray / Other Diagnostic Tests

On the diagram please mark any areas of tenderness:



MASSAGE THERAPY INFORMED CONSENT TO TREATMENT

I understand that the massage therapist is providing massage therapy services within their scope of practice as defined by the Massage Therapist Association of Saskatchewan, Inc., or the Natural Health Practitioners of Canada.

I hereby consent for my therapist to treat me with massage therapy for the above noted purposes including such assessments, examinations, and techniques, which may be recommended, by my therapist.

I acknowledge that the therapist is not a physician and does not diagnose illness or disease or any other physical or mental disorder. I clearly understand that massage therapy is not a substitute for a medical examination. It is recommended that I see my physician for any ailments that I may be experiencing. I acknowledge that no assurance or guarantee has been provided to me as to the results of the treatment. I acknowledge that with any treatment there can be risks and those risks have been explained to me and I assume those risks.

I acknowledge and understand that the therapist must be fully aware of my existing medical conditions. I have completed my medical history form as provided by my therapist and disclosed to the therapist all of those medical conditions affecting me. It is my responsibility to keep the massage therapist updated on my medical history. The information I have provided is true and complete to the best of my knowledge.

I have read the above noted consent and I have had the opportunity to question the contents and my therapy. By signing this form, I confirm my consent to treatment and intend this consent to cover the treatment discussed with me and such additional treatment as proposed by my therapist from time to time, to deal with my physical condition and for which I have sought treatment. I understand that at any time I may withdraw my consent and treatment will be stopped.

Patient Name (please print): ____

Patient Signature: ____________________________________ Date Signed: _____________________________________

Signature of Parent or Guardian (if under the age of 18): ____

Witness: ____ Date Signed: ___________________________________