



**Massage Therapy
PATIENT INFORMATION**

Date: _____

Name: _____

Address: _____

Postal Code: _____

Phone Numbers: Area Code Number Extension

Home: _____ _____

Phone (bus): _____ _____ _____

Phone (cell): _____ _____

Email: _____

Date of Birth (D/M/Y) _____

Emergency Contact: _____ Phone # _____

Insurance Provider: _____ Phone # _____

Adjuster: _____ Claim # _____

How did you hear about us? Web Site Referral _____ Sign

Type of Work: _____

1. Place a check mark if you suffer from any of the following:

- | | | |
|--------------------------|-----------------------------|--------------------------------|
| diabetes _____ | migraines _____ | joint disease _____ |
| tension headaches _____ | heart problems _____ | skin disease _____ |
| kidney disease _____ | digestive disease _____ | high blood pressure _____ |
| infectious disease _____ | respiratory disease _____ | joint or muscle injuries _____ |
| areas of numbness _____ | areas of chronic pain _____ | paralysis _____ |

List any other conditions not mentioned : _____

2. Are you taking medication? Y or N

If yes, please list: _____

3. Have you ever had local steroid injections to combat inflammation? Y or N
If yes, please list: _____

4. In regards to the muscles and joints of the body;

- do your muscles cramp easily or often? Y or N
- indicate which muscles usually suffer from tension, soreness, etc.
back ___ neck ___ jaw ___ shoulder ___ arms ___
chest ___ legs ___ wrists ___ hips ___

5. Which joints are often stiff and sore? _____

6. Are there any areas of your body you would feel uncomfortable having massaged?
Please specify: _____

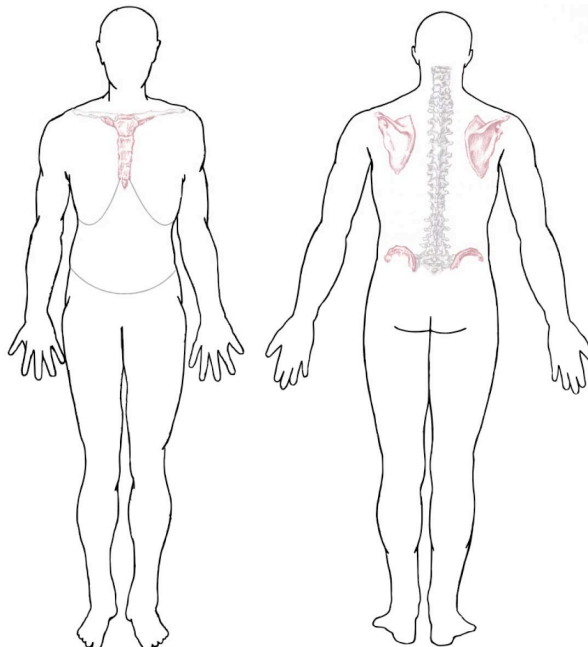
7. Have you suffered from any accidents, trauma or surgeries?
Please specify: _____

8. Previous treatment from other health care professionals:
Please specify: _____
Subjective improvements: _____

9. Please indicate your interest in the following benefits of massage:
(1 indicates great interest, 5 indicates little interest)

- tension release 1 2 3 4 5
- improvement of athletic performance 1 2 3 4 5
- education on preventing muscle and joint problems 1 2 3 4 5
- relaxing treatment 1 2 3 4 5
- relief of pain or stiffness 1 2 3 4 5

10. Mark the area(s) of pain or unusual feeling using the appropriate symbols. **CIRCLE** the areas of **PAIN**. "X" over areas of **JOINT & MUSCLE STIFFNESS**, Draw **SQUIGGLY LINES** along areas of **NUMBNESS, TINGLING OR ALTERED SENSATION**.
Additional comments: _____



Clinic Information

* Please Read and Sign

Office Hours

Monday 9 – 5 pm	Tuesday 8 – 5 pm	Wednesday 9 – 5 pm	Thursday 8 – 5 pm	Friday 8 – 12 pm
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Pricing

PAYMENT IS DUE WHEN SERVICE IS RENDERED. Payment is accepted in the form of cash, cheque, debit card, Mastercard and Visa.

Service

Massage Therapy 1 ½ hours	\$ 120.00
Massage Therapy 1 hour	\$ 80.00
Massage Therapy 45 minutes	\$ 65.00
Massage Therapy 30 minutes	\$ 50.00

Missed Appointments	\$20.00	\$20.00
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Upon request, our office will be happy to print you statements to submit to your insurance company for reimbursement. **WE DO NOT BILL SECONDARY INSURANCE COMPANIES ON YOUR BEHALF**, but we will be happy to assist you with your individual insurance forms.

Signature

Date