Back to Back Massage Therapy Intake Form

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Fees and Cancellation Policy:

Please check with each massage practitioner for massage prices, as they are individual to each practitioner. Massage therapists cannot bill directly to MSP, ICBC, WCB or any other healthcare plans. Payment of your massage session is due at the time of each visit.

If you are unable to make your massage appointment, 24 hours notice is required. In cases of missed appointments, or when insufficient notice of cancellation is given, you will be **charged a NO SHOW/Late Cancellation Fee equal to the appointment fee**.

Appointment fees are as follows:	Initial	$95.00
	30 min.	$55.00
	45 min.	$75.00
	60 min.	$95.00

Please note: While we try to call and remind you of your appointment the day before, it is best **not** to rely on reminder calls. Also, we do **not** book, cancel or reschedule appointments by email, please give us a call and we'd be more than happy to assist you with any booking changes.

Patient Consent

Your massage therapist makes every effort to ensure that your treatment is safe and effective. At any time, before or during therapy, you have the right to ask that the treatment, or portion of the treatment, be discontinued, or inquire about the purpose of any technique being used. If at any time you have questions or concerns related to the treatment we encourage you to communicate with your therapist so there may be clarification or modification of the treatment. This case history form will be kept as part of your patient file. All information including the case history will be kept confidential and will not be released without prior consent.

Please sign below that you understand the above information and that the information provided in this case history is accurate. Signing will also indicate your consent for treatment.

_____ _____

Patient Signature (or Legal Guardian) **Date**

_____

Printed Name

Address:_____ Birth Date:_____ Care Card:_____

_____ Occupation:_____

Home Phone:_____ Emergency Contact:_____

Work Phone:_____ _____

Cell Phone:_____ Medical Doctor:_____

PLEASE LIST ALL ALLERGIES: _____

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1. Reason for seeking care/major complaint(s):

1) _____

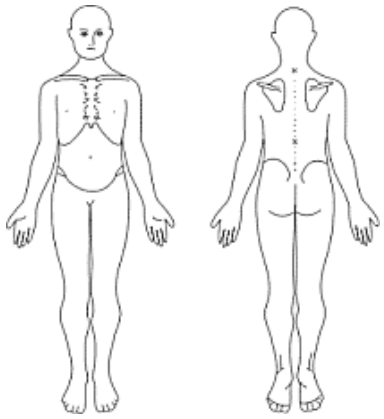
2) _____

3) _____

2. Onset of pain: ❍ Sudden ❍ Gradual ❍ Injury

Cause of Injury: _____

Please indicate area(s) of pain:



3. On a scale of 1-10 (0 being no pain to 10 being unbearable pain):

How would you rate your pain today?: _____

How would you rate your pain on average?: _____

4. What aggravates the pain? _____

5. What relieves the pain? _____

6. Has this condition occurred before? ❍ No ❍ Yes

If yes, how so? _____

7. How does the pain affect your daily routine? _____

_____

8. Please list all medications you are currently taking: _____

_____

9. Are you currently seeing any other practitioners?

❍ R.M.T. ❍ Physiotherapist ❍ Chiropractor ❍ Acupuncturist ❍ Other _____

10. Please list ANY accidents, illnesses, or other injuries: _____

_____

11. Do you have/wear: ❍ Implants ❍ Steel Pins ❍ Foot Supports ❍ Glasses/Contact Lenses

Other: _____

12. Are you satisfied with your:

Overall Health:	❍No ❍Yes	Ability to Relax:	❍No ❍Yes	Sleep:	❍No ❍Yes
Energy Level:	❍No ❍Yes	Fitness Level:	❍No ❍Yes	Diet:	❍No ❍Yes

13. Medical History - Please mark all that apply to you: ✗ = Past ✓ = Present

❍ Allergies	❍ Fractures	❍ Insomnia
❍ Arthritis	❍ Head Injuries	❍ Jaw Pain
❍ Cancer	❍ Headaches	❍ Respiratory Issues
❍ Circulatory Condition	❍ Heart Condition	❍ Seizures
❍ Contagious Condition	❍ Hepatitis A/B/C	❍ Skin Condition
❍ Diabetes	❍ High/Low Blood Pressure	❍ Spinal Injury
❍ Dislocation	❍ HIV/AIDS	❍ Sprains/Strains
❍ Fainting	❍ Infection	❍ Stroke

❍ Pregnant: _____ Or trying to conceive?: _____

❍ Please list any pregnancy complications you have or have had? _____

❍ Other: _____