Confidential Patient Intake Form
Personal Information

Name:	**Date:**	
Email:	**Birthdate:**	
Home Phone:	**Address:**	
Cell Phone:		
Fax Phone:	**City:**	**Postal Code:**
Personal Health Number:	**Province:**	**Country:**

Occupation:	
Employer:	Work Phone:
Family Doctor:	
Phone:	Email:
Emergency Contact:	
Phone:	Relationship:
Parent/Guardian:	
Home Phone:	Cell Phone:

Communication Consent:	
Y / N Email 2 days before appointment?	Y / N Send notifications of new/cancelled appointments?
Y / N Text 2 hours before appointment?	Y / N Send Clinic Communications emails?

How did you hear about us? *Check Boxes that apply & Fill in appropriate spots

- ☐ Friend/Relative
- ☐ Physician/Therapist
- ☐ Online Ad
- ☐ Web Search: ______________________
- ☐ Other: ______________________

For Office Use Only:

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Insurance Information

Date of Injury: ☐ WorkSafe ☐ ICBC Claim #:

Insurance Adjustor's Name: Phone:

Medical Information

Reason for Coming/Condition:

Does the pain/condition affect your daily activities?

If yes, how?

How would you like to benefit from Massage Therapy treatment? *Check all that apply

☐ Rehabilitation/Correction ☐ Injury Prevention/Health ☐ Pain Management ☐ Stress Reduction

How long has the pain/condition existed?

Has the condition occurred before? ☐ Yes ☐ No **Was it Resolved**? ☐ Yes ☐ No

Type of Pain: *Check all that apply

☐ Sharp/Excruciating ☐ Burning/Tingling ☐ Aching/Dull ☐ Other

What aggravates it?

What relieves it?

Is it worse in the: ☐ Morning ☐ Midday ☐ Evening ☐ Night ☐ Constant

Are you presently taking any medications? ☐ Yes ☐ No *Check all that apply

☐ Pain Killers ☐ Muscle Relaxants ☐ Anti-Inflammatory ☐ Depression/Anxiety

☐ Other Please List:

Do you have any allergies? ☐ Yes ☐ No Describe:

Have you had OR are you currently receiving treatment from any of the following?

☐ Massage Therapy ☐ Chiropractor ☐ Physiotherapy ☐ Acupuncture ☐ Naturopath

Other ☐ Please List:

Please list any previous accidents, illnesses, injuries and/or surgeries:

Please CIRCLE the extent to which you are currently satisfied with the following:

(1 = poor, 5 = excellent)

Diet	1	2	3	4	5	Physical Health & Fitness	1	2	3	4	5
Energy Level	1	2	3	4	5	Mental & Emotional Happiness	1	2	3	4	5
Ability to Relax	1	2	3	4	5	Quality of Sleep	1	2	3	4	5

Please CIRCLE your use of the following:

Water:	None	Light	Moderate	Heavy	Tobacco:	None	Light	Moderate	Heavy
Coffee:	None	Light	Moderate	Heavy	Sugar:	None	Light	Moderate	Heavy
Alcohol	None	Light	Moderate	Heavy	Salt:	None	Light	Moderate	Heavy

Please CIRCLE the amount of stress you are subject to: None Slight Moderate Severe

Please list any regular Exercise, Hobbies and/or Activities:

Please Circle if you have had in the Past, or Presently have, any of the following conditions; or if there's been a case(s) in your Family History.

AIDS/HIV	Past	Present	History	Head or Neck Trauma	Past	Present	History
Arthritis	Past	Present	History	Depression	Past	Present	History
Arteriosclerosis	Past	Present	History	Dizziness	Past	Present	History
Anemia	Past	Present	History	Fainting	Past	Present	History
Cancer	Past	Present	History	Nausea	Past	Present	History
Circulatory Disorder	Past	Present	History	Headaches	Past	Present	History
Chest Pains	Past	Present	History	Visual Problems	Past	Present	History
Contagious Disease	Past	Present	History	Ear Problems	Past	Present	History
Diabetes	Past	Present	History	Jaw Pain	Past	Present	History
Digestive Disorder	Past	Present	History	Neck Pain	Past	Present	History
Epilepsy	Past	Present	History	Upper Back/Shoulder Pain	Past	Present	History
Hemophilia	Past	Present	History	Mid Back Pain	Past	Present	History
Heart Condition	Past	Present	History	Low Back Pain	Past	Present	History
Hernia	Past	Present	History	Spinal Disc Injury/Disease	Past	Present	History
High/Low Blood Pressure	Past	Present	History	Arm/Wrist/Hand Pain	Past	Present	History
Organ Dysfunction	Past	Present	History	Leg/Ankle/Foot Pain	Past	Present	History
Osteoporosis	Past	Present	History	Fracture	Past	Present	History
Pregnancy	Past	Present	History	Dislocation	Past	Present	History
Respiratory Condition	Past	Present	History	Sprain/Strain	Past	Present	History
Ulcers	Past	Present	History	Unexplained/Sudden Weakness	Past	Present	History
Skin Condition	Past	Present	History	Numbness/Tingling	Past	Present	History
Stroke	Past	Present	History	Neurological Condition	Past	Present	History
Urinary Disorder	Past	Present	History	Loss of Sleep	Past	Present	History
Varicose Veins	Past	Present	History	Other:	Past	Present	History

Massage Therapy Fees

		Deanna	Anton	Bryan	John
Initial Visit	60 mins	$100*	$100*	$100*	$120*
Subsequent Visits	30 mins	$56*	$56*	$56*	$65*
	60 mins	$100*	$100*	$100*	$120*

*Includes GST

Please note: Each visit includes the following steps: Assessment, Evaluation, Treatment, and Patient education (exercise, homecare, etc).

Insurance Coverage:

- **MSP**: Please notify reception to confirm coverage.
- **WorkSafe**: Please notify reception to confirm claim acceptance and coverage.
- **ICBC**: ICBC rates may vary among therapists, please confirm fees with reception.
- **RCMP/DVA**: Private group plans cover therapy for RCMP officers and Veterans. Please confirm coverage with reception.

MD referral required for WorkSafe, ICBC, RCMP, DVA and some extended health plans.
Please check your coverage with your extended health insurance provider.

Full payment of fees is expected on the date of service or by specific arrangement made by the front desk. Please note that fees are subject to change without notice.

Fee Policy & Consent to Treatment: Please read the following and sign below.

In consideration of your fellow patients and your therapist please **allow a minimum of 24 hours notice to change or cancel your appointment**. This allows us to reschedule that time period.
Missed appointments and/or short notice cancellations will be charged 50% of the scheduled appointment fee. Please inform us if you are unable to make your appointment.

I understand and agree to the Fee Policy within this office. I agree to pay for any late cancellations or missed appointments, subject to my therapist's discretion. If at any time ICBC, WorkSafe, MSP or other third party refuses coverage I understand that it is my responsibility to pay the outstanding balance owed.

I hereby consent to receive treatment by Body Smart Health Inc. and its associates. I understand that this consent is fully voluntary and may be revoked by me at any time. I understand the fee structure and accept responsibility for prompt payment.

Patient's Signature: ________________________________ **Date:** ____________________