



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:

Insurance Information

Date of Injury:	<input type="checkbox"/> WorkSafe	<input type="checkbox"/> ICBC	Claim #:
Insurance Adjustor's Name:	Phone:		

Occupation:

Work Phone: _____

Family Doctor:

Phone: _____ Email: _____

Emergency Contact:

Phone: _____ Relationship: _____

Parent/Guardian:

Home Phone: _____ Cell Phone: _____

Communication Consent: Please read the following and initial/check boxes.

Emails:

_____ (Initial required) I understand and agree that Body Smart Health Inc. may need to contact me via phone or email with regards to appointment bookings (new bookings, changes to your bookings, reminders for upcoming appointments, cancelled, rescheduled and waitlist bookings).

- I would like to receive important clinic news and information by email.
- I would like email notifications of new, cancelled, and rescheduled appointments.
- I would like to receive an email two days before my appointment.
- I would like to receive a text message (SMS) 2 hours before my appointment.

How did you hear about us?

***Check Boxes that apply & fill in appropriate spots**

<input type="checkbox"/> Friend/Relative	<input type="checkbox"/> Physician/Therapist	<input type="checkbox"/> Online Ad
<input type="checkbox"/> Web Search: _____	<input type="checkbox"/> Other: _____	

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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/Excruating 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	John	Student/Senior Pricing
Initial Visit	60 mins	\$110 Plus GST	\$120 Plus GST	\$100 Plus GST
Subsequent Visits	30 mins	\$60 Plus GST	\$65 Plus GST	\$56 Plus GST
	60 mins	\$110 Plus GST	\$120 Plus GST	\$100 Plus GST
	90 mins	\$165 Plus GST	\$180 Plus GST	\$150 Plus GST

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

Insurance Coverage:

- **MSP/WorkSafe/ICBC:** Please notify reception to verify and confirm coverage.
- **RCMP/VAC** are billed through Medavie Blue Cross directly. Please notify reception to confirm coverage and to set up your account.
- We direct bill to extended health plans. Please notify reception to confirm coverage and to set up your account.

MD referral is required for some third-party insurers such as RCMP/VAC and some extended health plans. Please check your coverage with your extended health insurance provider.

FEE POLICY & CONSENT TO TREATMENT: Please read the following and initial and sign below.

_____ (Initial required) I understand and agree that if at any time a third-party insurance refuses coverage, it is my responsibility to pay the outstanding balance owed.

_____ (Initial required) I understand and agree that 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.

Cancellation Policy:

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 a fee.** Please inform us if you are unable to make your appointment.

_____ (Initial required) I understand and agree to the Cancellation Policy. I agree to pay for any late cancellations or missed appointments subject to my therapist's discretion. **Late cancellation or missed appointment fees cannot be billed to third party insurers.**

Privacy and Sharing of Information:

I authorize the clinic and its associated health professionals to collect my personal and medical information as documented in this intake form. In addition, I authorize the clinic and its associated health professionals to communicate with my family doctor and/or referring practitioners as deemed necessary for my beneficial treatment. I also understand that my personal and medical information is confidential and will only be disclosed to third parties with my permission.

_____ (Initial required) I understand and agree to the Privacy and Sharing of Information policy.

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:** _____