

Back to Back Massage Therapy Intake Form

Gwen Cole R.M.T. ~ Alicia Doll R.M.T.~ David Warbeck C.M.T.



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	\$70.00
30 min.	\$45.00
45 min.	\$70.00
60 min.	\$85.00

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.

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: _____

Home Phone: _____

Occupation: _____

Work Phone: _____

Emergency Contact: _____

Cell Phone: _____

Medical Doctor: _____

Back to Back Massage Therapy Intake Form

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

2. Onset of pain: Sudden Gradual Injury

Please indicate area(s) of pain:

Cause of Injury: _____

3. What aggravates the pain? _____

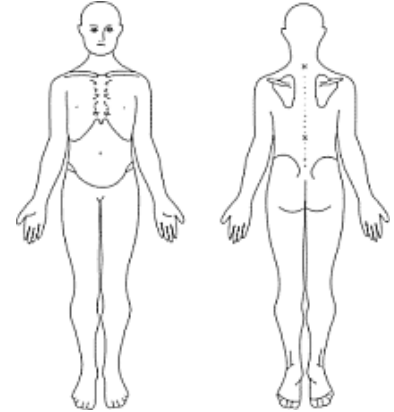
4. What relieves the pain? _____

5. Has this condition occurred before? No Yes

If yes, how so? _____

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

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



8. Are you currently seeing any other practitioners?

R.M.T. Physiotherapist Chiropractor Acupuncturist Other _____

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

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

Other: _____

11. 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

12. 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

Pregnancy: # _____ Complications: _____

Other: _____

Office Use: