client intake form

date of initial visit

personal information

name date of birth

address

city province postal code

home phone cell phone

work phone ext.

email address

occupation

referred by

emergency contact name(relationship) emergency contact phone

Physician's name physician's phone

massage experience

Have you had a therapeutic massage before? ❒ Yes ❒ No

If yes, what types of massage have you had? swedish, shiatsu, deep tissue etc?

manual osteopathic experience

Have you had a manual osteopathic treatment before? Y ____ N ____

If yes, what for? _____

current health

reason for initial visit _____

Do you exercise regularly/and or participate in any sports? ❒ Y ❒ N
If yes, what kind of exercise/sports? _____

Do you perform any repetitive movement in your work, sports or hobby? ❒ Y ❒ N
If yes, describe _____

Do you sit for long hours at a workstation, computer or driving? ❒ Y ❒ N
If yes, describe _____

Do you experience stress in your work,family or other aspect of your life? ❒ Y ❒ N
If yes, describe _____

Are you experiencing tension, stiffness, discomfort or pain? Y ___N___
If yes, describe _____

Have you, within the last 72hrs, had an injury,surgery or areas of inflammation? ❒ Y ❒ N
If yes, describe _____

Do you have sensitive skin? ❒ Y ❒ N

Do you have allergies to oils, lotions or ointments? ❒ Y ❒ N
If yes, please explain _____

List any medications you are currently taking _____

List any known allergies _____

health history

Please indicate current conditions with a **C** and Previous conditions with a **P**

Soft tissue/joint/nerve

___ Fibromyalgia
___ Chronic Fatique
___ Scoliosis
___ Arthritis __RA__OA
___ Herniated Disk(s) Level ____
___ Osteoporosis
___ Fracture (where:_____)
___ Thoracic Outlet Syndrome
___ Head Trauma/concussion
___ Whiplash/car accident
___ Neck pain/stiffness/injury
___ Shoulder pain/stiffness/injury
___ Arm/hand pain/weakness/tingling
___ Back pain/stiffness/injury
___ Leg pain/weakness/injury
___ Knee or foot pain/injury
___ Tendinitis/Thenosynovitis
___ Bursitis or dislocations

Respiratory

___ Breathing difficulties/Asthma
___ Emphysema
___ Chronic cough
___ Smoker/Vape
___ Sinus Infections

Cardiovascular

___ Heart Condition
___ High/low blood pressure
___ CCHF or Heart Attack
___ Stroke/CVA
___ Pacemaker or other devices
___ Phlebitis/Varicous Veins
___ Poor healing of wound
___ Cold hands/feet
___ Swelling in hands/feet

Skin

___ Bruise easily

___ Rashes/open sores/warts
___ Cosmetic Surgery
___ Athlete's Foot
___ Contagious Skin Disease

Digestive

___ Constipation
___ Nausea/vomiting
___ Ulcers/blood in stool
___ Liver/kidney problems
___ Quick weight loss/gain
___ Appetite Changes
___ Ulcerated Colitis/Chrohn's/IBS

Infections

___ Hepatitis
___ Tuberculosis
___ HIV

Head and Neck

___ Tension/ migraine headaches
___ Tinnitus (ringing in ears)
___ Tooth/jaw/ear pain
___ Vision problems/loss
___ Dizziness/lightheaded/vertigo
___ Seizures

Other

___ Cancer (type) _____
___ Diabetes (type) _____
___ Epilepsy
___ Insomnia
___ Depression
___ Multiple Sclerosis

Reproductive

___ Pregnant, due date _____
___ Painful menstruation
___ Hysterectomy
___ C-Section
___ Birth control

client agreement & health release form

primary insurance plan- health benefits

group number | plan number

insured's full name | insured's date of birth

insurance information

Is your condition a result of an auto accident? ❒ Yes ❒ No

If so, in what province did the accident occur? _____

❒ A work injury? ❒ A health condition? ❒ Other? _____

What type of insurance do you have that may cover you for this condition? (check all that may apply)

❒ Auto ❒ Worker's compensation ❒ Liability ❒ Health

Was a police/accident report filed ❒ Yes ❒ No

Client's relation to insured ❒ Self ❒ Spouse ❒ Partner ❒ Child ❒ Other

insured's full name | insured's date of birth

ins ID # | date of injury

client's full name

address

city | province | postal code

home phone | cell phone

work phone

client agreement for manual osteopathy

It is my choice to receive manual osteopathy. I am aware of the benefits and risks of manual osteopathy and give my consent for a manual osteopathy treatment. I understand that there is no implied or stated guarantee of success or effectiveness of individual techniques or series of appointments. I understand that manual osteopathy is not a substitute for medical care, medical examination or diagnosis. I have stated all medical conditions that I am aware of an will inform my practitioner of any changes in my health status. I understand that this form has been provided as a reference and is not held liable for any services provided.

signature | date

client agreement for massage therapy

It is my choice to receive massage therapy. I am aware of the benefits and risks of massage therapy and give my consent for a massage therapy treatment. I understand that there is no implied or stated guarantee of success or effectiveness of individual techniques or series of appointments. I understand that massage therapy is not a substitute for medical care, medical examination or diagnosis. I have stated all medical conditions that I am aware of an will inform my practitioner of any changes in my health status. I understand that this form has been provided as a reference and is not held liable for any services provided.

signature | date

assignment of benefits

I am responsible for all charges for all service provided. In the unfortunate event that my insurance company denies payment, or makes partial payment, I am responsible for the balance due.

I authorize direct payment of medical benefits to my massage therapist_____ for services billed

signature | date

signature of parent of legal guardian (if client is a minor)

release of medical records

I authorize the release of medical records or other health care information, including intake forms, chart notes, reports, correspondence, billing statements, and other written information to my attorneys , healthcare providers, and insurance case managers, for the purposes of processing my claims.

signature | date

signature of parent of legal guardian (if client is a minor)

(Please inform your practitioner immediately upon signing any exclusive Release of Medical Records with your attorney that may impact the release statement.

contract for care

I will participate fully as a member of my healthcare team. I will make sound choices regarding my sessions' plan based upon the information provided by my massage therapist. I agree to participate in my own self-care programs and adhere, to the best of my abilities, to the plan we select. I agree to communicate with my practitioner any time I feel my well being is being compromised. I expect my practitioner to provide safe and effective treatment to the best of her skills and knowledge.

signature | date

signature of parent of legal guardian (if client is a minor)