



Massage Therapy New Client Form

We would like to welcome you to New Balance Chiropractic Clinic, where it is our mission to provide you with the best holistic solutions for your individual needs. Before getting started, we believe it is crucial to get to know you and your situation intimately. Your health is our primary concern. If we believe our services are not the best solution for your individual needs, we will refer you to the appropriate health care provider.

Patient Identification

Name: _____ Gender: Male Female
Address: _____ City: _____ Prov: _____ Postal Code: _____
Telephone: Home: _____ Work: _____ Cell: _____
Email: _____ Date of Birth (m/d/y): _____ Age: _____
Insurance Provider: _____ Policy # / Member ID: _____
Occupation: _____ Employer: _____
Emergency Contact: _____ Phone Number: _____
Alberta Health Care #: _____ Family Physician: _____
Date of last exam: _____

Referral Type: Google Facebook Live/work in Area Referral by: _____

Would you prefer appointment reminders via: home phone cell phone work phone email

Previous Chiropractic Care: Yes No Name of Chiropractor: _____

When: _____ Reason for visit: _____

Previous Massage Therapy: Yes No Name of Therapist: _____

When: _____ Reason for visit: _____

Patient Acceptance

Unless prior arrangements have been made, payment is due in full when services are rendered.
WCB and motor vehicle accident cases will be billed directly.

Cancellation Notice: Your appointment is an opportunity to address your health concerns. It is our goal to provide this opportunity in a timely manner to all members of the community. We respectfully ask that you provide at least 24 hours notice if cancellation is required. Please note that missed or cancelled appointments without appropriate notice will result in a charge of 50% of scheduled services being applied to your account.

I, the undersigned, understand and accept the statements above and that the practitioners of New Balance Chiropractic Clinic have the right to refuse or discontinue treatment at any time.

Signature _____

Date _____

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Patient History

Do you exercise?: Yes No How much? _____

Activities: _____

Do you smoke? Yes No How much? _____

How much water do you consume daily? _____

Do you consume alcohol? Yes No How much? _____

Have you ever been diagnosed with any of the following? Please check all that apply:

- | | | | |
|------------------------------------------|---------------------------------------------|--------------------------------------------------|--------------------------------------------------|
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Epileptic Seizures | <input type="checkbox"/> Low/High Blood Pressure | <input type="checkbox"/> Neurological Disease |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Stroke | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Cardiovascular Disease |
| <input type="checkbox"/> Thyroid Disease | <input type="checkbox"/> Liver Disease | <input type="checkbox"/> Kidney Disease | <input type="checkbox"/> Musculoskeletal Disease |

Have you ever or do you currently experience any of the following symptoms/conditions?

Please check all that apply:

- | | | |
|---------------------------------------------|-----------------------------------------------------------|---------------------------------------------------------|
| <input type="checkbox"/> Asthma/Emphysema | <input type="checkbox"/> Anxiety/Depression | <input type="checkbox"/> Hernia/Ulcer |
| <input type="checkbox"/> Chest Pain | <input type="checkbox"/> Skin Condition/Sensitivity | <input type="checkbox"/> Eye/Ear/Nose Pain |
| <input type="checkbox"/> Migraine | <input type="checkbox"/> Sexually Transmitted Disease/HIV | <input type="checkbox"/> Difficulty Hearing |
| <input type="checkbox"/> Nausea/Vomiting | <input type="checkbox"/> Unexplained Weight Loss/Gain | <input type="checkbox"/> Cardiac Pacemaker |
| <input type="checkbox"/> Abdominal Pain | <input type="checkbox"/> Sinus/Respiratory Infections | <input type="checkbox"/> Allergy/Food Intolerance |
| <input type="checkbox"/> Difficulty Seeing | <input type="checkbox"/> Shortness of Breath | <input type="checkbox"/> Anemia/Blood Clotting Disorder |
| <input type="checkbox"/> Corrective Eyewear | <input type="checkbox"/> Dizziness/Fainting | <input type="checkbox"/> Fever |
| <input type="checkbox"/> Easily Bruised | <input type="checkbox"/> Indigestion/Heartburn | <input type="checkbox"/> Broken/Fracture/Dislocation |

Females only: # of Pregnancies _____ # of Children _____

Currently pregnant: Yes No

Have you ever experienced difficulties with your menstrual cycle (cramps, headaches, etc)? Yes No

Please list all current **medications** and **supplements**, including dose and frequency:

Please list all **hospitalizations/surgeries**, including date and diagnosis:

Please list any previous **major traumas** (falls, motor vehicle accidents, sports injuries, etc):

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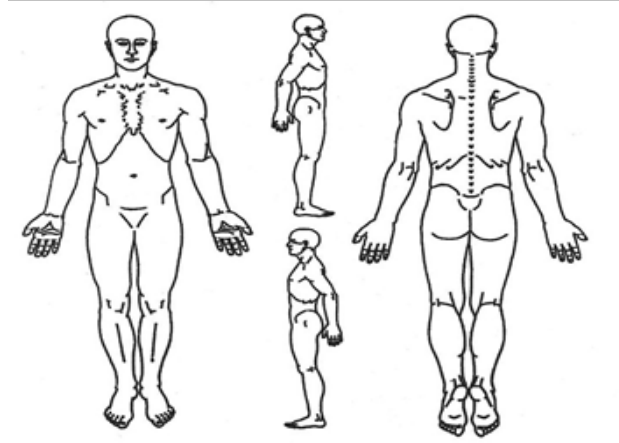
Current Complaint

Is your current complaint related to a work injury? Yes No

Is your current complaint related to a motor vehicle accident? Yes No

Please describe your primary symptoms:

Please indicate the location of your symptoms:



When did your symptoms first start? _____

How often do you experience symptoms?

Minimally Weekly Every Other Day Daily All the Time

On a regular basis, how would you rate the intensity of your symptoms? Place an "X" on the scale below.

No pain Worst possible pain

Describe your symptoms:

- | | | |
|-----------------------------------------|------------------------------------|---------------------------------------|
| <input type="checkbox"/> Stiffness | <input type="checkbox"/> Tingling | <input type="checkbox"/> Dull Ache |
| <input type="checkbox"/> Crampy | <input type="checkbox"/> Shooting | <input type="checkbox"/> Numbness |
| <input type="checkbox"/> Sharp/Stabbing | <input type="checkbox"/> Throbbing | <input type="checkbox"/> Other: _____ |

When are your symptoms the worst?

- Morning Mid-Day Night Other: _____

What aggravates your symptoms?

- | | | |
|------------------------------------------|--------------------------------------------|---------------------------------------|
| <input type="checkbox"/> Lifting | <input type="checkbox"/> Sitting | <input type="checkbox"/> Standing |
| <input type="checkbox"/> Inactivity/Rest | <input type="checkbox"/> Activity/Exercise | <input type="checkbox"/> Light/Noise |
| <input type="checkbox"/> Stress | <input type="checkbox"/> Fatigue | <input type="checkbox"/> Other: _____ |

What relieves your symptoms?

- | | | |
|------------------------------------------------------|-------------------------------------|------------------------------------------|
| <input type="checkbox"/> Ice | <input type="checkbox"/> Heat | <input type="checkbox"/> Inactivity/Rest |
| <input type="checkbox"/> Activity/Exercise/Stretches | <input type="checkbox"/> Medication | <input type="checkbox"/> Other: _____ |

What are your goals for treatment?

- | | | |
|-------------------------------------------------------------|--------------------------------------------------|--------------------------------------------------------|
| <input type="checkbox"/> Relieve symptoms | <input type="checkbox"/> Overall wellness | <input type="checkbox"/> Increase functional abilities |
| <input type="checkbox"/> Reduce stress | <input type="checkbox"/> Improve range of motion | <input type="checkbox"/> Improve posture |
| <input type="checkbox"/> Improve range of health & wellness | | |

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Informed Consent to Massage Therapy Treatment

- a) I have filled out a completed/updated Health History form and have had an opportunity to ask any questions that I may have to clarify and better understand why an accurate health history is needed before massage begins.
- b) The massage therapist has explained to me the nature and purpose of the proposed assessment/reassessment, treatment, and/or remedial plans. I understand that results are not guaranteed.
- c) I am aware that I may discontinue the assessment/reassessment, treatment, and/or remedial exercise plan at any time.
- d) I further understand and have been informed that, as in all health care, in the practice of the massage therapy there are some very slight risks to treatment, including, but not limited to; muscle strains and soreness, disc injuries, possible bruising and strokes. I do not expect the Massage Therapist to be able to anticipate and explain all risks and complications and I wish to rely on the Massage Therapist to exercise judgment during the course of the procedure which the massage therapist feels at the time, based upon the facts then known, is in my best interest.
- e) I also confirm that I have the ability to accept or reject this care of my own free will and choice and that I am not an agent of any private, local, provincial, or federal agency attempting to gather information without so stating.
- f) Draping will be used during the session – only the area being worked on will be uncovered. A parent or legal guardian for any client under the age of 18 must provide informed written consent. If for any reason written consent is not obtainable, contact information must be provided for his/her parent or legal guardian.
- g) I understand the fee structure and accept full responsibility for prompt payment.

I acknowledge I have read this consent and I have discussed, or been offered the opportunity to discuss, with my massage therapist the nature and purpose of massage therapy in general, the treatment options and recommendations for my condition, and the contents of this consent.

I consent to the treatment recommended to me by the massage therapists of New Balance Chiropractic Clinic. I intend this consent to apply to all my present and future massage therapy treatments at New Balance Chiropractic Clinic.

Patient Name _____ Patient Signature _____

Witness Name _____ Witness Signature _____

Date _____

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