Balanced Health and Sports Therapy

Chiro ● Physio ● Massage

MASSAGE INTAKE AND RELEASE FORM

NAME _____ DATE OF BIRTH: D ____ M ____ Y _____

ADDRESS _____ CITY _____

POSTAL CODE: _____ PHONE (H) _____(W) _____(C)_____

Please mark if you would like to receive our monthly newsletter: Yes ☐ No ☐

OCCUPATION: _____ COMPANY: _____

ARE YOU CURRENTLY TAKING MEDICATION: YES ☐ NO ☐

If **YES** LIST ALL MEDICATION(S): _____

WHAT CONDITION(S) ARE THE MEDIACATION(S) FOR:_____

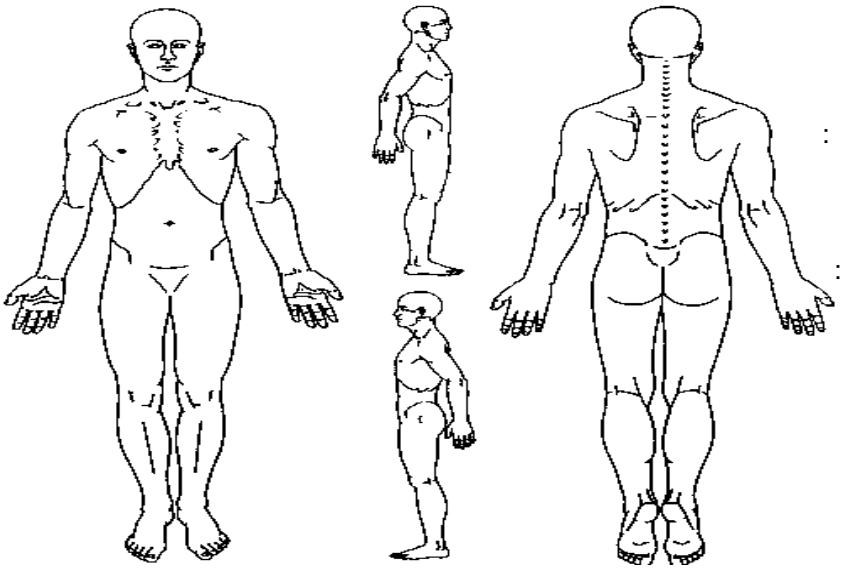
ARE YOU CURRENTLY RECEIVING CHIROPRACTIC CARE: YES ☐ NO ☐

IF YES WITH WHOM: _____

ARE YOU RECEIVING ANY OTHER THERAPIES OR TREATMENTS: YES ☐ NO ☐

IF YES PLEASE DESCRIBE: _____

MARK THE AREA(S) OF THE DIAGRAM WHERE YOU FEEL PAIN AND/OR DISCOMFORT.



IF YOU ARE CURRENTLY EXPERIENCING OR HAVE EXPERIENCED ANY OF THE FOLLOWING, PLEASE CHECK:

__ HIGH BLOOD PRESSURE	__ STRESS	__ SEIZURES
__ LOW BLOOD PRESSURE	__ HEADACHES	__OTHER LIST:
__ HEART DISEASE	__ ALLERGIES	_____
__ CIRCULATORY PROBLEMS	__ BLOOD CLOTTING DISORDERS	_____
__ ARTHRITIS	__ SKIN PROBLEMS	_____
__ DIABETES	__ ANY CONTAGIOUS DISEASES	
__ JOINT PROBLEMS	__TMJ DYSFUNCTION	

1519 – 19th Street NW, Calgary, AB T2N 2K2
Phone: (403) 282-0880 Fax: (403) 282-0898

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__ BURSITIS __ BACK and/or NECK PAIN

WOMEN ONLY: ARE YOU PREGNANT: YES ☐ NO ☐

HOW OFTEN DO YOU EXERCISE: _____

ANY INJURIES, SURGERIES AND/OR MOTOR VEHICLE ACCIDENTS: YES ☐ NO ☐

WHEN:_____ DESCRIBE: _____

HOW DID YOU HEAR ABOUT US: _____

WHY HAVE YOU COME FOR MASSAGE: _____

PLEASE REMOVE ANY JEWELERY FROM THE AREA BEING MASSAGED. IF YOU WEAR CONTACT LENSES OR DENTURES IT IS RECOMMENDED THAT YOU REMOVE THEM FOR YOUR OWN COMFORT.

I UNDERSTAND THAT PAYMENT IS EXPECTED AT THE TIME OF VISIT.

I UNDERSTAND THAT I WILL BE CHARGED THE FULL APPOINTMENT FEE ON ALL MISSED APPOINTMENTS OR CANCELLATIONS WITHOUT 24 HOURS NOTICE.

PLEASE READ THOUROUGHLY AND SIGN WHERE INDICATED BELOW

I UNDERSTAND THAT MASSAGE IS GIVEN HERE FOR THE PURPOSE OF STRESS REDUCTION, RELIEF FROM MUSCULAR TENSION, MUSCLE SPASM OR PAIN, AND/OR FOR INCREASING CIRCULATION.

I UNDERSTAND THAT THE MASSAGE THERAPIST DOES NOT DIAGNOSE ILLNESS, DISEASE OR ANY OTHER PHYSICAL OR MENTAL DISORDER. AS SUCH, THE MASSAGE THERAPIST DOES NOT PRESCRIBE MEDICAL TREATMENT OR PHARMECEUTICAL TREATMENT, NOR DO THEY PERFORM MANIPULATIONS. IT HAS BEEN MADE CLEAR TO ME THAT MASSAGE IS NOT A SUBSTITUTE FOR MEDICAL EXAMINATION OR DIAGNOSES.

I HAVE STATED ALL MY KNOWN MEDICAL CONDITIONS AND TAKE IT UPON MYSELF TO KEEP THE MASSAGE THERAPIST UPDATED ON MY PHYSICAL HEALTH.

_____ _____

SIGNATURE of Patient (or parent/guardian) **DATE**

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