METROTOWN
MASSAGE THERAPY

MASSAGE THERAPY INTAKE FORM

Last Name	First Name	Email Address		
Is this your preferred name? ❑ Yes ❑ No	If No, please indicate your preferred name.	Birth date (MM.DD.YR)	Age:	Gender Pronoun: ❑ He ❑ She ❑ They
Home address:		Phone Number ( )		
City: Province: Postal Code:		Personal Health Number (PHN):		
Occupation:	Employer:	Work Phone Number ( )		

Referred to clinic by (please check one box): ❑ Dr. _____ ❑ Google ❑ Yelp

❑ Friend/Family Member: _____ ❑ Close to home/work ❑ Other: _____

Primary reason for visit (Please Describe):

EXTENDED HEALTH INFORMATION FOR DIRECT BILLING

Extended Health Insurance Provider: ❑ Great West Life ❑ Sunlife ❑ Pacific Blue Cross ❑ Manulife ❑ Other: _____

Member ID: _____ Policy/Plan Number: _____

Name of the Primary Card Holder: _____

Birthday of Primary Card Holder (MM.DD.YR): _____

Is today's visit related to an ICBC motor vehicle accident or WorkSafeBC injury?
❑ Yes
❑ No

If **YES**, please list the following:

Date of the Accident (MM.DD.YR): _____

Claim Number: _____

Adjuster Name: _____

Adjuster Phone Number: _____

EMERGENCY CONTACT

Name of local friend or relative (not living at same address):	Relationship to patient:	Home phone no.:	Work phone no.:
		( )	( )

MISSED APPOINTMENT POLICY + MSP ASSIGNMENT

I authorize Medical Services Plan to pay Metrotown Massage Therapy directly for all reimbursements for benefits payable to me under the Medical and Health Care Services Regulation for care provided to me at this clinic. I make this assignment in full knowledge of the amount that I will personally be responsible for and the amount that is reimbursable by the Medical Services Plan which will be directed to Metrotown Massage Therapy to be applied against any outstanding monies I owe for services provided.

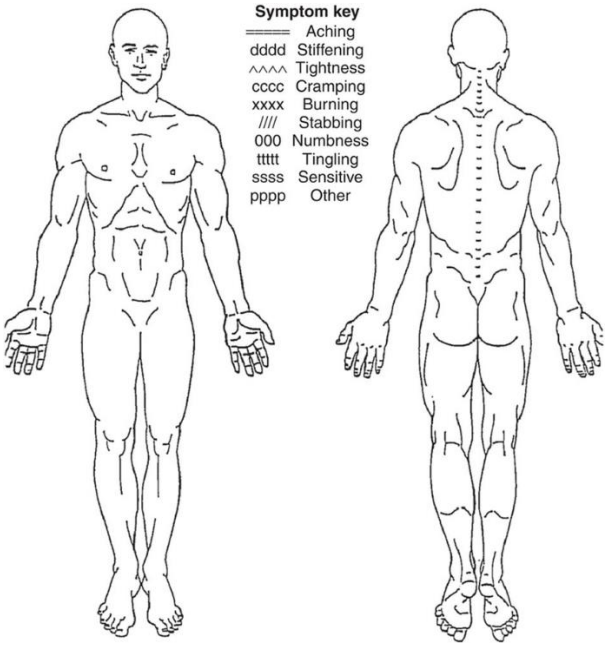
I understand that I am financially responsible for medical services provided to me and missed appointments. If I am unable to keep an appointment, I must provide the clinic at least 24 hours' notice to cancel otherwise the full amount of the treatment will be invoiced. There are three ways to modify/cancel an existing appointment:

1. Call the clinic: 604-430-1525
2. Visiting our website and logging onto our online booking platform https://metrotownmassagetherapy.com/
3. Email info@metrotownwellness.com

By Signing below, I consent to the above policies

Patient/Guardian signature *Date*

Please Indicate the Location of your Complaint



Schedule A – I acknowledge and confirm that the areas of my body circled on the above diagram will be touched by the RMT during the course of my treatments at the clinic. If there are any concerns, please notify your registered massage therapist before treatment begins.

HEALTH QUESTIONNAIRE

Please list any medications you currently take, and if you have a history of any medical conditions:

Have you ever had any fractures? If yes, where and when?

Do you suffer from headaches?

Have you sought previous therapy for this complaint? (eg. Physiotherapy/Registered Massage Therapy/Chiropractic)

Please add any additional comments that would be relevant to your practitioner:

CONSENT TO TREATMENT

Patient Name:_____ DOB: (dd/mm/yy): ___/___/___

- **Read this document, including Schedule "A", carefully and completely. It is important.**
- Please be sure to ask your RMT any questions you have about this form or its contents BEFORE you sign this document.
- You have the right at any time to ask questions about your treatment.
- Please be sure to immediately advise your RMT if you become uncomfortable with any aspect of your treatment, so that they may stop and discuss it with you.

The Treatment: I authorize and consent to the RMT performing the following specific treatments on me:

__ Soft Tissue Mobilization __Joint Mobilization __Exercise Therapy
__Other:_____

Risks, Complications & Side Effects: I acknowledge and understand that:

- There are risks associated with any manual therapy techniques, including those techniques used by Registered Massage Therapists. Examples include bruising, aching, discomfort, short term aggravation of symptoms, muscle and ligament strains, sprains and skin irritation;
- **I have discussed any specific concerns I have about possible risks with my Therapist before signing this document**;
- The nature and purpose of the above treatments, the possible alternative methods of treatment, the risks involved and the possible complications and side effects have been fully explained to me by the RMT;
- I do not expect the RMT to be able to anticipate and explain all possible risks, complications and side effects of my treatment(s) to me; and
- I wish to rely on the RMT to exercise their judgment during the course of the treatment to provide the treatment that is in my best interests.

Disclosure of Medical History: I acknowledge and understand that:

- It is important for the RMT to know my medical history as it may relate to my treatment(s);
- I have disclosed to the RMT in writing all medical conditions, including any mental or emotional conditions for which I have received treatment, currently affecting me and those that have affected me in the past;
- I will immediately disclose in writing any medical condition that I subsequently realize I have not already disclosed, including any new condition that may develop after my completion of this form; and
- The information disclosed by me is true and complete to the best of my knowledge.

Confidentiality: The contents of this form and my patient records will be kept confidential unless I have expressly or impliedly consented to the release of my information or where there is a legal requirement to provide my information to a third party.

No Guarantee of Results: I acknowledge and confirm that no guarantee or assurance of results has been made to me regarding my treatments.

Signature of Patient*: _____ Date: (dd/mm/yy): __/__/__

(* In the case of a person incapable of providing consent, signature of Parent or Guardian, in which case the Name & Relationship of Person Signing: _____.)