



CONFIDENTIAL CLIENT INTAKE FORM

First Name: _____

Last Name: _____

Birthdate: _____
(DD/MM/YY)

Gender: _____

How did you hear about us? (Please check as many boxes that apply)

- | | |
|--|---|
| <input type="checkbox"/> Website/Search Engine | <input type="checkbox"/> BNI Business Network International |
| <input type="checkbox"/> Flyer | |
| <input type="checkbox"/> Facebook | <input type="checkbox"/> Location: Drove/Walked by |
| <input type="checkbox"/> Twitter | |
| <input type="checkbox"/> LinkedIn | <input type="checkbox"/> Family/Friend: _____ |
| <input type="checkbox"/> Google+ | |
| <input type="checkbox"/> Instagram | <input type="checkbox"/> Other: _____ |

Occupation: _____

Employer: _____

Mobile #: _____

Alternate #: _____

Street Address: _____

City/Town: _____

Postal Code: _____

Email Address: _____

How would you prefer to receive appointment notifications? **Email** or **Text**

Do you have any allergies? If yes, please list: _____

-----**Office Use Only**-----

<input type="checkbox"/> MB: Phone <input type="checkbox"/> Text/Email reference	<input type="checkbox"/> MB: Allergies	<input type="checkbox"/> Scanned Ins <input type="checkbox"/> Attached Ins
<input type="checkbox"/> MB: Referral	<input type="checkbox"/> MB: DOB	<input type="checkbox"/> Telus Connect
<input type="checkbox"/> MB: Address <input type="checkbox"/> MB: Email	<input type="checkbox"/> Scanned PIF <input type="checkbox"/> Attached PIF	<input type="checkbox"/> Initial when done

Have you ever received a therapeutic massage?

Yes / No

Have you ever received treatment from a Manual Osteopath?

Yes / No

Purpose of this visit? (Main Complaint) _____

When did this symptom first appear? _____

Have you had the same or similar symptom before?

Yes / No

Are you currently taking any prescription or over the counter medications?

Yes / No

If Yes, please list: _____

Do you play sports or exercise regularly?

Yes / No

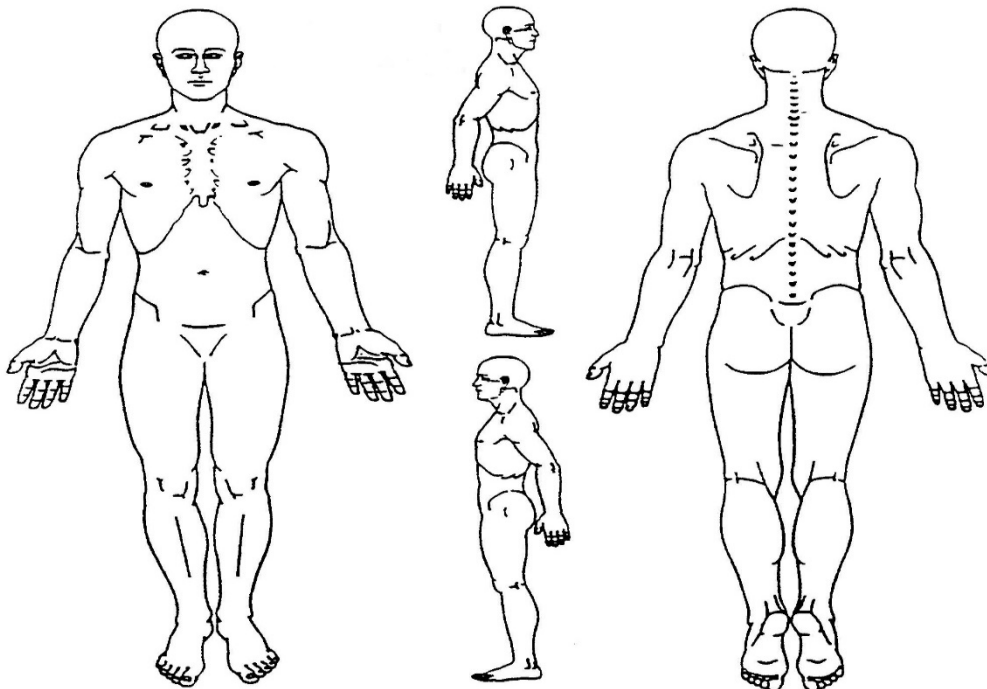
If Yes, please explain: _____

Have you ever had an accident/injury or required surgery?

Yes / No

If Yes, please explain including dates: _____

Place an "X" where you are experiencing pain and use the 1(low) -10 pain(high) scale to rate the intensity of the pain.





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Please check all conditions listed below that apply to you:

- | | |
|--|---|
| <input type="checkbox"/> Shingles | <input type="checkbox"/> Currently pregnant |
| <input type="checkbox"/> Open sores or wounds | Due date: _____ |
| <input type="checkbox"/> Bruise easily | <input type="checkbox"/> Currently smoke |
| <input type="checkbox"/> Artificial joint | <input type="checkbox"/> Headaches or migraines |
| <input type="checkbox"/> Pins or plates | <input type="checkbox"/> Atherosclerosis |
| <input type="checkbox"/> Sprain or strain injury | <input type="checkbox"/> Phlebitis |
| <input type="checkbox"/> Heart condition or pacemaker | <input type="checkbox"/> Deep vein thrombosis or blood clots |
| <input type="checkbox"/> Blood pressure conditions | <input type="checkbox"/> Joint or arthritic disorder |
| <input type="checkbox"/> Varicose veins | <input type="checkbox"/> Tendonitis |
| <input type="checkbox"/> Carpal tunnel syndrome | <input type="checkbox"/> Bursitis |
| <input type="checkbox"/> Intrauterine device (birth control) | <input type="checkbox"/> Osteoporosis |
| <input type="checkbox"/> CPAP Machine | <input type="checkbox"/> Cancer |
| <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Fibromyalgia |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Breast augmentation or reduction surgery |
| <input type="checkbox"/> TMJ disorder (jaw clicks) | |

Manual Osteopath Treatments requires loose fitting clothes or workout attire for your comfort during the treatments.

Massage Therapy will utilize draping, only the area being worked on will be uncovered.

A parent or legal guardian must accompany all clients under the age of 16 during their entire session.

INFORMED CONSENT

I, (full name) _____, understand that the **MASSAGE** or **MANUAL OSTEOPATH** treatment I receive is provided for the basic purpose of relaxation and/or therapeutic treatment for musculoskeletal dysfunction. If I experience any pain or discomfort during any session, I will immediately inform the therapist so that the pressure may be adjusted to my level of comfort. I further understand that massage or manual osteopath treatments should not be construed as a substitute for a medical examination, diagnosis or treatment and that I should seek the advice of a medical practitioner for all medical concerns. I also understand that Lensen and Osteopath Therapists are efficiently trained to detect and correct spinal and joint imbalances throughout the skeletal system using gentle mobilising osteopathic corrective techniques. Because massage and manual osteopath therapies should not be performed under certain medical conditions, I affirm that I have stated all known medical conditions and answered all questions honestly. I agree to keep the therapist updated with any changes in my medical profile and understand that there shall be no liability on the therapist's part should I fail to do so.

CANCELLATION/INSURANCE BENEFIT POLICY:

A no show appointment is limited to one only at no cost. After one no-show appointment, all future appointments require a credit card on file. Any future no show appointments will be billed direct to the credit card and/or the insurance on file.

A minimum of three hours is required to cancel an appointment without it being a short notice cancellation. Two short notice cancellations (less than three hours) will be allowed before a credit card is required on file. After that, any short notice cancellations will be direct billed to the credit card and/or the insurance on file.

Black Rock Therapies offers the service of direct billing to all major insurance companies. However, if the benefit company does not cover full or partial costs of the treatment, the client is responsible for the full treatment cost. It is the responsibility of the client to understand their benefit plan and to notify Black Rock Therapies of any changes or cancellations.

Any personal information collected by Black Rock Therapies, including all insurance benefit and credit card information will be kept confidential.

Signature of Client

or Parent/Legal Guardian:

Today's Date:

Signature of Therapist:
