Black Rock Therapies
MASSAGE & MANUAL OSTEOPATH

CONFIDENTIAL CLIENT INTAKE FORM

First Name: _____ **Last Name:** _____

Birthdate: _____ **Gender:** _____
(DD/MM/YY)

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

- ❑ Website/Search Engine
- ❑ Flyer
- ❑ Facebook
- ❑ Twitter
- ❑ LinkedIn
- ❑ Google+
- ❑ Instagram
- ❑ BNI Business Network International
- ❑ Location: Drove/Walked by
- ❑ Wellness News
- ❑ The Advocate
- ❑ Family/Friend: _____
- ❑ 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**----------

❑ MB: Phone ❑ Text or Email	❑ MB: Allergies	❑ Scanned Ins ❑ Attached In
❑ MB: Referral	❑ MB: DOB ❑ MB: Gender	❑ Telus Connect
❑ MB: Address ❑ MB: Email	❑ Scanned PIF ❑ Attached PIF	❑ Initial when done ❑ Initial on double check

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

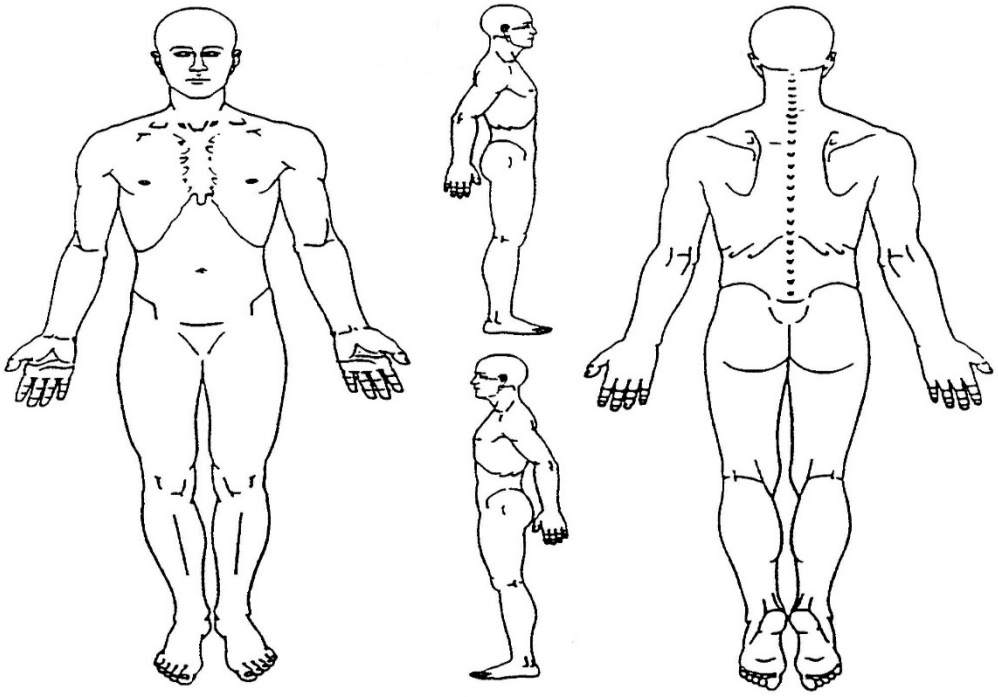
If Yes, please explain: _____

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:

- ❑ Artificial joint
- ❑ Atherosclerosis
- ❑ Blood pressure conditions
- ❑ Breast augmentation or reduction surgery
- ❑ Bruise easily
- ❑ Bursitis
- ❑ Cannabis use – CBD or THC
- ❑ Cancer
- ❑ Carpal tunnel syndrome
- ❑ CPAP Machine
- ❑ Currently pregnant
  Due date: _____
- ❑ Currently smoke
- ❑ Deep vein thrombosis or blood clots
- ❑ Diabetes
- ❑ Epilepsy
- ❑ Fibromyalgia
- ❑ Headaches or migraines
- ❑ Heart condition or pacemaker
- ❑ Intrauterine device (birth control)
- ❑ Joint or arthritic disorder
- ❑ Open Sores or wounds
- ❑ Osteoporosis
- ❑ Phlebitis
- ❑ Pins or plates
- ❑ Shingles
- ❑ Sprain or strain injury
- ❑ Tendonitis
- ❑ TMJ disorder (jaw clicks)
- ❑ Varicose veins

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: _____