Blackfalds Chiropractic Centre
5007 Broadway Ave.
P.O. Box 1510
Blackfalds, AB. T0M 0J0
Phone: 403-885-5808

Massage Therapy

Date: _____

Patient's Name: _____ Alberta Healthcare #:_____ Sex: M F

Mailing Address: _____ City: _____ Province: _____ Postal Code: _____

Home#: _____ Work#: _____ Cell #: _____

Email: _____ Would you like Emailed Receipts? No Yes

Would you like reminders of your upcoming appointments by: Emailed Text (if text) Service Provider_

Date of Birth: D/____ M/____ Y: _____ Age: _____ Married: ___ Single: ___ How Many Children: ____ Occupation: _____

Emergency Contact: _____ Phone #: _____

Who may we thank for referring you to our office? _____ Is this W.C.B? No Yes

Medical Doctor? _____ Date of last visit? _____

Chiropractor? _____ Date of last visit? _____

Massage Therapist? _____ Date of last visit? _____

1. What is the purpose of this appointment? Wellness / Relaxation Automobile Accident Other _____
2. Reason for discomfort? Work School Other _____
3. Have you seen a Medical Doctor or Chiropractor for this condition? No Yes Date: _____
4. What was recommended? _____ Did it help your condition? No Yes
5. What aggravates your condition? _____
6. Have you had surgery? No Yes Date: _____
7. What medications are you taking, including over the counter? _____
8. Have you broken any bones? No Yes if yes, which bones? _____
9. Do you have any skin rashes? No Yes if yes, what? _____
10. Car accident or Major Injuries? No Yes if yes, what? _____ When? _____
11. Do you take vitamins or minerals? No Yes
12. **Females:** Are you pregnant? No Yes
13. Are you suffering from any of the following:

Allergies/Hay fever	Low back pain	Tuberculosis	Itching	Bursitis
Dizziness	Neck pain/stiffness	Hypoglycemia	Psoriasis/Eczema	Anemia
Fatigue	Poor Posture	Bruise easily	Bedwetting	Colds / Flu
Headaches/Migraines	Cancer	Nose bleeds	Frequent Urination	Deafness
Loss of Sleep	Spinal Curvatures	Sinus Infection	Kidney Infection/stone	Ear Noise
Stroke	Colon Trouble	Heart Disease	Hemorrhoids	Diabetes
Ulcers	Swollen Joints/Ankles	Menstrual Cramps	Nausea	Chest Pain
Numbness	Pain over Heart	Irregular Cycle	Enlarged Thyroid	Prostate Trouble
Arthritis	Rapid/slow Heartbeat	Poor Circulation	Hot Flashes	Eye pain/bad vision
Asthma	High Blood Pressure	Difficulty Breathing	Difficult Digestion	Nervousness/Depression
Alcoholism	Low Blood Pressure	Chronic Fatigue Syndrome	Fibromyalgia	Aids/HIV Positive
Sciatica				

Other: _____

See other side

12. Do you have any family history of illness? _____

13. Describe Your Habits:

	Heavy	Moderate	Light	None
Alcohol	◯	◯	◯	◯
Coffee	◯	◯	◯	◯
Tobacco	◯	◯	◯	◯
Exercise	◯	◯	◯	◯
Sleep	◯	◯	◯	◯
Soft Drinks	◯	◯	◯	◯
Water	◯	◯	◯	◯

14. Is there anything else that you feel is important for us to be aware of? ☐ No ☐ Yes

Please comment: _____

PAYMENT IS EXPECTED AT THE TIME OF VIST!

Name of person responsible for Payment_____

I understand and agree that all services rendered are charged directly to me and that I am personally responsible for payment. I also understand that if I suspend or terminate my care, any fees for professional services rendered will be immediately due and Payable.

Patient / Guardian Signature: _____ Date: _____

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Massage Therapy Consent Form

I understand that the massage I receive is provided for the basic purpose of relaxation, stress reduction and relief of muscle tension. If I experience any pain or discomfort during the session, I will immediately inform the therapist so that the pressure or strokes may be adjusted to my level of comfort.

I further understand that massage should not be construed as a substitute for medical examination, diagnosis, or treatment and that I should see a physician, chiropractor, or other qualified medical specialist for any mental or physical ailment I am aware of.

I understand that Massage Therapists are not qualified to perform spinal or skeletal adjustments, diagnose, prescribe, or treat any physical or mental illness, and that nothing said during the session given should be construed as such.

Because massage should not be performed under certain medical conditions, I affirm that I have stated all my known medical conditions and answered all questions honestly. I agree to keep the massage therapist updated as to any changes in my medical profile and understand that there shall be no liability on the massage therapists' part should I fail to do so.

Printed Name:_____ Date: _____

Parent Signature/Legal Guardian Signature:_____

My signature below acknowledges the cancellation policy at Blackfalds Chiropractic Centre.
If I fail to show up for a scheduled appointment or do not provide a minimum of 24 hours' notice when cancelling, I will be responsible for the full charge of the missed massage appointment.
With my consent, in the event I miss an appointment, BCC can charge the credit card below. I understand that my information will be saved to file for future transactions on my account.

Card Holder Name (as shown on card):_____

Card Number:_____ Expiry Date: CVV:_____

Card Type: ◯ Master Card ◯ Visa

Signature:_____