



Kensington **Health** Group
REGISTERED MASSAGE THERAPY
CLIENT INTAKE FORM

GENERAL & MEDICAL INFORMATION

Name: _____ Date: _____

Is this your first massage? YES NO

Why have you come for a massage? Stress / Pain Relief / Tension / Other _____

Is your condition work related? YES NO

Are you currently having discomfort or pain? YES NO

Do you know the cause of the pain? _____

Does anything aggravate the pain? _____

Does anything relieve the pain? _____

Can you describe the pain? (e.g. tingling, numbness, burning, radiating...)

Where do you hold stress in your body? _____

Are you currently taking any medication? _____

Please specify: _____

Are you receiving chiropractic care or other medical treatment?

Accidents, injuries or surgeries:

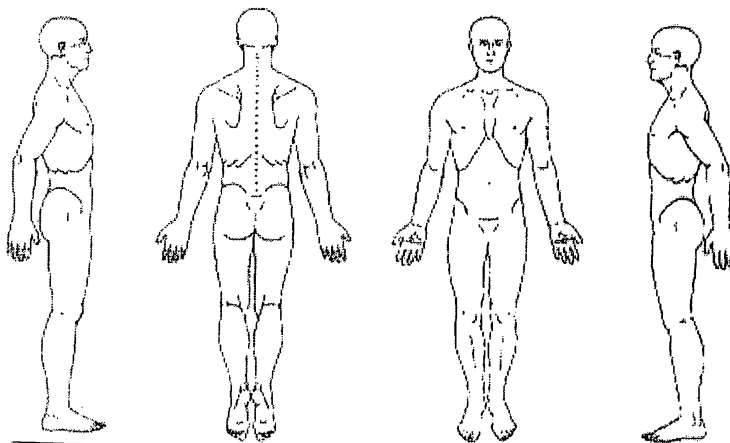
More than 5 years ago: _____

Less than 5 years ago: _____

GO TO NEXT PAGE.....



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Mark any key areas of pain/discomfort in the diagram above

INFORMED CONSENT

I understand that massage is given here for the purpose of stress reduction; relief from muscular tension, spasm, or pain; or for increasing circulation or energy flow.

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 pharmaceutical, nor do they perform spinal manipulations. It has been made clear to me that massage is not a substitute for medical examination or diagnoses and that it is recommended that I see a physician for any physical ailment I might have.

Since massage therapy is contraindicated under certain conditions, I affirm that I have stated all my known medical conditions to the best of my knowledge and take it upon myself to keep the massage therapist updated on my physical health.

Print Name

Signature

Date

This information is collected under the authority of the *Personal Information Protection Act, Personal Information Protection and Electronic Documents Act, and the Health Information Act.* It is required to provide health service. This information will form part of your clinical file.

EXPLANATION OF MASSAGE WESTJET FEES

The purpose of this page is to clarify your financial responsibilities so we can devote our efforts to helping you get the best results in the shortest amount of time.

Length	Fee *
15 Minutes	\$25.00
30 Minutes	\$40.50
45 Minutes	\$58.50
60 Minutes	\$76.50
90 Minutes	\$112.50

*All fees exclude tax

Forms of Payment:

Patients are responsible for full payment at the time services are rendered. We accept interac, visa, mastercard, cash, or personal cheques. Any credit arrangements must be authorized in advance.

Third Party Insurance Coverage:

All professional services are rendered and charged to the patient receiving care and not to an insurance provider. We will supply you with statements, reports, or other documents for a fee, if applicable, as outlined above, to help you receive reimbursement from a third party.

Missed Appointments:

If you cannot make your appointment please call the office to inform us at least 3 hours before your scheduled time so that another patient may be booked during that time. At the discretion of the practitioner, a fee up to the total fee, as described above, may be charged for missed appointments or appointments cancelled within 3 hours of the scheduled time.

I have read, understood, and agreed to the fees and payment obligations as listed above.

Patient/Parent/Guardian Signature

Date