BODY MECHANICS
MASSAGE THERAPY CLINIC

(https://www.thebodymechanicsmassagetherapy.com

Intake form — Sample Sample

You are completing the intake form: **Patient Intake Form** for **Sample Sample**

You're completing the intake form as a staff member.

Section 1

Only staff members can edit this information on an intake form.

First Name – *Required*

Sample

Last Name – *Required*

Sample

Email – *Required*

Email Address

Preferred Name (if different)

Please provide at least one phone number. Your mobile number can be used to look up your Account and receive text message appointment reminders.

Mobile Phone – *Required*

CA (

A mobile phone is required if you would like to receive SMS appointment reminders.

Home Phone

CA (

Country – *Required*

Canada

Street Address – *Required*

Suite Number (i.e. Suite #100)

ity – *Required*

Delta

rovince – *Required*

British Columbia

ostal / Zip – *Required*

ate of Birth – *Required*

Gender – *Required*

Refers to current gender which may be different than what is indicated on your insurance policies or medical record.

Sex – *Required*

This field may be used for submitting claims to your insurance provider. Please ensure the sex you provide here matches what your insurance provider has on file or what is indicated on your medical record.

Personal Health Number – *Required*

Occupation

Guardian

Emergency Contact – *Required*

Emergency Contact Phone – *Required*

Emergency Contact Relationship – *Required*

Family Doctor

Family Doctor Phone (if known)

Family Doctor Email (if known)

How did you hear about us? – *Required*

How did you hear about us?

Who were you referred to?

Body Mechanics Massage Therapy LTD

Section 2

Medical History

Please specify for the following medical history information or indicate NONE or N/A if they do not apply to you. Thank you

Are you pregnant? If yes, please indicate how far along – *Required*

- [ ] Yes
- [ ] No

Please List any known Allergies (including medications, foods, seasonal, oils and lotions etc.) – *Required*

Do you have any family history of medical conditions? Please list: – *Required*

Please indicate if you have recently been hospitalized over night, had any major accidents, injuries, illnesses, or surgeries: – *Required*

Do you have any foreign bodies? Please indicate, (IUD, pacemaker, screws or plates, wire mesh, etc.): – *Required*

Are you receiving or have you received other therapy/ treatment such as Massage Therapy, Chiropractor, Physiotherapy, Naturopath, Acupuncture or Other (Please specify): – *Required*

Please indicate conditions you are experiencing by clicking the following for: Skin Conditions – *Required*

☐ Rash ☐ Psoriasis ☐ Eczema ☐ Other ☐ None

Muscular/ Joint Conditions: – *Required*

☐ Weakness or loss of strength ☐ Osteoporosis/ Osteopenia ☐ Rheumatoid Arthritis ☐ Osteoarthritis ☐ Sprain/ Strain ☐ Tendonitis ☐ Other ☐ None

Respiratory Conditions – *Required*

☐ Asthma ☐ Bronchitis ☐ Difficulty breathing ☐ Emphysema ☐ Smoking ☐ Other ☐ None

Cardiovascular Condition – *Required*

☐ High Blood Pressure ☐ Low Blood Pressure ☐ Heart attack ☐ Stroke ☐ Poor circulation ☐ Other ☐ None

Head/ Neck – *Required*

☐ Headaches ☐ Visual impairment ☐ Migraines ☐ Concussion ☐ Post-concussion ☐ Hearing impairment ☐ Jaw pain (TMJD) ☐ Speech impairment
☐ Sinus problems ☐ Other ☐ None

l Tract – *Required*

☐ Gas ☐ Constipation/ Diarrhea ☐ Painful elimination ☐ Other ☐ None

ental Health – *Required*

☐ Depression ☐ Anxiety ☐ PTSD ☐ Dementia ☐ Other ☐ None

☐ Diabetes ☐ Cancer ☐ Fainting ☐ Fever ☐ Insomnia ☐ Stress ☐ Numbness/ tingling ☐ Liver/ kidney/ bladder condition ☐ Other ☐ None

Please indicate any OTHER conditions not listed above that may apply to you:

Current Condition

BELOW PLEASE COMMENT ON YOUR CURRENT CONDITION:

Please indicate the closet answer to how you presently feel: (1=poor, 2=average, 3=good, 4=very good, 5=excellent)

Quality of Sleep.

☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5

Energy Level

☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5

Please describe your fitness level and form of activity:

Area of Concern

PLEASE COMMENT ON YOUR CURRENT CONDITION

Please indicate the area of concern (head, neck, shoulder, arm, back, legs etc), and describe your current symptoms (sharp, achy, tight, sore, restricted etc.): *– Required*

How long have you you had this for?

How did it start?

What aggravates it?

What relieves it?

Thank you for taking the time to fill in our Online Patient Intake Form!

A kind reminder to complete all intake forms online prior to your visit, as we are paperless.

It is very important that you do not attend your appointment if you are feeling unwell, are awaiting test results for COVID-19 for yourself or someone in your house hold, if yo have had a potential exposure, have been overseas to any country in the past 14 days, or have been advised to remain in quarantine, please let us know as soon as possible and we will reschedule.

Please be honest with us about these concerns. We will consider circumstances and be flexible with cancellations during this time. You will not be charge for last minute cancellations in regards to all of the situations listed above, however a no show fees may still apply.

This is in consideration of your health and safety, as well as the well-being of other patients and team members.

If you have any questions or concerns, do not hesitate to bring them to our attention.

We appreciate your support, cooperation and understanding. We are excited to treat our community!

Section 3

Email Communication

Transactional Emails

You can opt to receive emails to keep you informed of new bookings, changes to your bookings, and reminders for upcoming appointments.

- [x] I would like email notifications of new, cancelled, and rescheduled appointments
- [ ] Phone Call 2 days before appointment
- [ ] Text Message (SMS) 4 hours before appointment
- [ ] Email 2 days before appointment
- [ ] Text Message (SMS) 24 hours before appointment

News and Special Promotions

- [ ] Yes, I would like to receive news and availability notices by email.

Patient Intake Form — Consents

Accuracy of Information

- [ ] I certify that the above medical information is correct to my knowledge. – *Required*

Privacy and Sharing of Information

I authorize Body Mechanics Massage Therapy LTD Clinic and its associated health professionals to collect my personal and medical information as documented above. In addition, I authorize the clinic and its associated health professionals to communicate with my family doctor and/or referring doctor as deemed necessary for my beneficial treatment. I also understand that my personal and medical information is confidential and will only be disclosed to third parties with my permission. I understand the Practitioner is the rightful custodian of my charts.

- [ ] I agree – *Required*

24 Cancellation policy

- [ ] Your appointment time is reserved just for you. A late cancellation or missed visit leaves a hole in the therapists' day. As such, we require 24 hours notice for any cancellations or changes to your appointment. Patients who provide less than 24 hours notice, or miss their appointment, will be charged a cancellation fee. You will be required to pay for any treatment related fees which have not been or are covered by your health insurance. I am aware of the Cancellation Policy. I accept the conditions outlining by Body Mechanics Massage Therapy LTD. Cancellation Policy and I give full consent for treatment. I am aware of the Cancellation Policy. – *Required*

Contact Policy

- [ ] I authorize Body Mechanics Massage Therapy LTD and its associates to collect my personal information and medical information as documents in this form in order to contact me and give permission for the clinic to leave messages regarding appointments at any of the contact information I have provided. – *Required*

Signature

○ Draw ○ Type