



MESSAGE INTAKE FORM

First Name: _____ Last Name: _____

Preferred Name: _____ Prefix/Title: _____

Cell: _____ Home: _____

Address: _____
(Street) (City, Province) (Postal Code)

Date of Birth: _____ Gender: _____ Sex: M / F
(DD / MM / YYYY)

Alberta Health Number: _____ Guardian: _____

Occupation: _____ Employer: _____

Emergency Contact Phone: _____ Emergency Contact Name: _____

Emergency Contact Relationship: _____

=====

Family Doctor: _____

Family Doctor Phone: _____ Family Doctor Email: _____

Name of referring professional: _____

Referring Prof. Phone: _____ Referring Prof. Email: _____

=====

WELCOME! We'd appreciate knowing if anyone referred you for massage.

Were you referred to anyone specific at the clinic? ☐ Yes ☐ No

To whom were you referred? _____

Who referred you? _____

Your Health Care Team: (please check applicable box(es) and provide practitioner name)

- ☐ Chiropractor _____
- ☐ Physiotherapist _____
- ☐ Naturopath _____
- ☐ Acupuncturist _____
- ☐ Psychologist/Counsellor _____
- ☐ Nutritionist _____
- ☐ Other _____

Injury/Accident History: (please provide details)

Type of injury/accident:

Date injury/accident occurred:

Treatment received for injury/accident:

Current symptoms from injury/accident:

Lifestyle Questions: (please provide details)

Major illnesses and surgeries:

Medications and supplements:

Lifestyle Questions (cont'd): (please provide details)

Exercise and self-care activities:

Treatment and wellness goals:

Current major complaint(s): (please provide details)

Area of body affected. _____

Quality of pain experienced _____

Onset of pain (date) _____

Initial cause of pain _____

Duration and frequency of pain _____

What provokes the pain _____

What relieves the pain _____

Past treatment(s) sought for the pain _____

Current major complaint(s) (cont'd): (please provide details)

Other notes

Where do you rate your pain?

No pain 0 1 2 3 4 5 6 7 8 9 10 Worst Pain

General Health:

Conditions:

- | | | |
|------------------------------------|---------------------------------------|-------------------------------------|
| ☐ Cancer | ☐ Osteoporosis | ☐ Depression |
| ☐ Diabetes | ☐ Osteopenia | ☐ Fainting |
| ☐ Hepatitis | ☐ Stroke | |
| ☐ Arthritis | ☐ Asthma | |

Please share brief details about any conditions checked above

Respiratory:

- | | | |
|---|--|-----------------------------------|
| ☐ Difficulty breathing | ☐ Chronic cough | ☐ Wheezing |
|---|--|-----------------------------------|

Please share brief details about any conditions checked above

Joints:

- | | | |
|---|--------------------------------------|---------------------------------------|
| ☐ Swollen joints | ☐ Achy joints | ☐ Stiff joints |
|---|--------------------------------------|---------------------------------------|

Please share brief details about any conditions checked above

General Health (cont'd):

Cardiovascular:

- | | | |
|--|---|---|
| ☐ Palpitations | ☐ Heart Attach | ☐ Chest pain |
| ☐ High blood pressure | ☐ Low blood pressure | ☐ Poor circulation |

Please share brief details about any conditions checked above

Musculoskeletal:

- | | | |
|--|--------------------------------------|-------------------------------------|
| ☐ Neck pain | ☐ Elbow pain | ☐ Knee pain |
| ☐ Upper back pain | ☐ Wrist pain | ☐ Ankle pain |
| ☐ Low back pain | ☐ Pelvic pain | |
| ☐ Shoulder pain | ☐ Hip pain | |

Please share brief details about any conditions checked above

Neurological:

- | | | |
|--|--|--|
| ☐ Sciatica | ☐ Difficulty speaking | ☐ Nausea/vomiting |
| ☐ Dizziness | ☐ Difficulty swallowing | ☐ Headaches |
| ☐ Double vision | ☐ Difficulty walking | ☐ Muscle weakness |
| ☐ Falls of no cause | ☐ Numbness | |

Please share brief details about any conditions checked above

Gastrointestinal:

- | | | |
|--|---|--|
| ☐ Stomach pain | ☐ Difficult defecation | ☐ Loss of bowel control |
| ☐ Poor appetite | ☐ Loose stool | ☐ Heartburn |

Please share brief details about any conditions checked above

General Health (cont'd):

Genito-urinary:

- | | | |
|---|--|--|
| ☐ Frequent urination | ☐ Difficult urination | ☐ Loss of bladder control |
| ☐ Kidney infection | ☐ Painful urination | |

Please share brief details about any conditions checked above

Female Health:

- | | | |
|---|--|--|
| ☐ Menstrual irregularity | ☐ Vaginal pain/infections | ☐ Difficulty conceiving |
| ☐ Menstrual cramping | ☐ Endometriosis/ovarian cysts | ☐ Breast pain |
| ☐ Painful menstruation | ☐ Miscarriage | ☐ Currently pregnant |

Please share brief details about any conditions checked above

Other:

- | | | |
|--|--|--|
| ☐ Fever | ☐ Weight loss | ☐ Pain at night |
| ☐ Worsening of symptoms | ☐ Difficulty sleeping | ☐ Stress |
| ☐ Anxiousness | | |

Please share brief details about any conditions checked above

Communication

Appointment Notifications and Reminders

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

Email ☐ Email 2 days prior to appointment

Text Message (SMS)

Standard messaging & data rates may apply, messaging frequency can vary and you can update your preferences anytime.

☐ Text Message (SMS) 2 hours prior to appointment

News and Special Promotions

☐ Yes, I would like to receive clinic updates and health and wellness information from the Vibe team of practitioners. This is usually sent on a monthly basis.

VIBE HEALTH & SPINE Inc.
Suite 310, 1918 Kensington Rd. NW, Calgary, Alberta T2N 3R5
Phone: 403-266-2283 Fax: 403-351-1690

Massage 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 the 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 agree. - Required

Cancellation, No Show and Late Arrival Policies

A credit card is required to reserve appointments of 1 hour (or greater) in length.

When an appointment is scheduled, it is reserved exclusively for you. If you cancel or miss the appointment without sufficient notice, it prevents another individual from booking that time slot resulting in lost opportunity for the therapist to provide their service and generate income. In our desire to be effective and fair to all clients, the following policies are honoured:

CANCELLATIONS: A FULL 24-hour advance notice is required when cancelling an appointment. If you are unable to give 24 hours advance notice you will be charged 100% of the booked service fee.

NO SHOWS: All no shows will be charged 100% of the booked service fee.

Phone calls and emails are time stamped therefore notifications delivered in this manner are subject to our Cancellation and No Show policies.

Cancellation and No Show fees will be automatically charged to your credit card.

LATE ARRIVALS: If you arrive late for your scheduled appointment, your appointment will still end at the scheduled time and you will be charged the full fee for the booked service. It is not the duty of the therapist to accommodate missed time and cannot be demanded.

☐ I confirm that I have read, fully understand, agree to the above policy, and agree to pay the fees associated with the service booked. I authorize Vibe Health & Spine to charge my credit card for any treatment that is not cancelled at least 24 hours prior to the booked service. I certify that I am an authorized user of the credit card on file and will not dispute this scheduled transaction with my bank or credit card company as long as the transaction corresponds to the terms indicated in this consent form. - Required

Signature: _____ Date: _____

Consent for Massage Therapy Treatment

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

I understand that the massage therapist does not diagnose illness, disease, or any physical or mental disorder. As such, the massage therapist does not prescribe medical or pharmaceutical treatment. It has been made clear to me that it is recommended that I see an appropriate doctor for any physical ailment I might have. I have stated all my known medical conditions and take it upon myself to keep the massage therapist updated on my physical health.

I understand the risks associated with massage therapy include, but are not limited to, superficial bruising, short-term muscle soreness, and exacerbation of undiscovered injury. I therefore release the clinic and massage therapist from all liability concerning these types of injuries that may occur as a result of the massage session.

I consent to treatment of the sensitive areas (chest wall muscles, breasts, gluteal muscles and upper inner thigh), should it be indicated upon assessment and clinically relevant.

I understand that it is my responsibility to inform my massage therapist of any discomfort I may feel during the massage session so he/she may adjust accordingly. I understand that I or the massage therapist may terminate the session at any time.

☐ I understand the above and consent to receive massage therapy treatment. - Required

Signature: _____ Date: _____