Massage Admittance Form

Kinetic Health® Registered Massage Therapy

Bay # 10, 34 Edgedale Drive NW.
Calgary, Alberta, Canada, T3A-2R4
Phone: 403-241-3772
Fax: 403-241-3846

Email: kinetichealth@shaw.ca

Date:

_____

Name:

_____
(Family Name) *(First Name)* *(Initials)*

Contact Information

Home Address:_____

Postal Code: _____ Phone (h):_____

Phone (w): _____ Phone (c): _____

Your Family Doctor (R**equired)**: _____]

Email Information

_____ _____ _____
Your Email Address *Patient's Initials* *Date*

☐ You agree that by providing this email address, and by initialing this document, that you have read the following *Terms of Usage*, and agree that we can send you email communications to confirm appointments, provide exercise and health instructions, provide health updates, service updates, and send information through clinic newsletters. You can opt-out of this service at any time.

Terms of Usage: Email addresses are strictly confidential and are never given out to other sources. We believe in a no- spam policy. We use emails to confirm appointments, provide you with exercises, health updates and clinical newsletters. Email also provides you with a means of asking your practitioner questions when they are not able to answer phone calls while treating patients. At any time, you can chose to opt-out of our email information services.

Emergency Contacts

Who should we contact if there is an emergency?

Name:_____ Phone:_____ _ _

What is your chief complaint - the primary reason for which you are coming to our clinic?
(Please provide a detailed description.)

Have you ever had Massage Therapy before? Yes ☐ No ☐

How did you hear about us at Kinetic Health?

Chief Complaints

- Describe the **onset** of this condition. Is your complaint related to a fall, an accident, or an auto accident? Please describe in detail.

- How long have you had this condition (**duration**)? How frequently does it occur?

- Do you have a **history** of similar conditions occurring in the past?

- Is the condition getting:
  - ☐ Worse
  - ☐ Same
  - ☐ Better
  - ☐ Consistent
  - ☐ Recurring

- How does the condition interfere with your work or activities of daily living?

- Is there a particular **time of day** when your condition is worse?
  - ☐ Morning
  - ☐ Afternoon
  - ☐ Evening
  - ☐ During the night
  - ☐ After long periods of activity

- Is this condition due to an **auto accident case**, or have you recently been in an accident?

  YES ☐ (Please explain) NO ☐

- Is this a **workman's compensation** case?

  YES ☐ NO ☐

- How would you describe the **character** of the pain that you are experiencing?
  - ☐ Persistent
  - ☐ Intermittent
  - ☐ Aching/Throbbing
  - ☐ Tingling
  - ☐ Numbness
  - ☐ Burning
  - ☐ Shooting
  - ☐ Radiating pain
  - ☐ Other

- What **aggravates** your condition?

- What relieves (**alleviates**) your condition?

- What types of treatment have you received for this condition? Please list and detail.

- Please provide the names of other practitioners that you have seen for this condition?

- What was the duration and frequency of the previous treatments for this condition?

- What were the **results** of previous treatments:
  - ☐ Poor
  - ☐ Fair
  - ☐ Good
  - ☐ Excellent
  - ☐ Other, please explain.

General Systems Review

Circle all applicable items or conditions.

Respiratory

Allergies
Asthma
Bronchitis
Chest Pain
Cough
Emphysema
Frequent Colds
Hay Fever
Pneumonia
Smoker
Trouble Swallowing

Skin

Acne
Boils
Color Changes
Dermatitis
Eczema
Fungal Infection
Dryness
Herpetic Infection
Itching
Lumps
Pain
Polyps
Psoriasis
Rashes
Scars
Shingles
Steroid Therapy
Swelling

Vision

Redness
Glaucoma
Light Sensitivity
Blurred Vision
Cataracts
Double Vision
Dyslexia
Tearing of the Eyes

Cardiovascular

Angina
Ankle Swelling
Arrhythmia
Arteriosclerosis
Blood Clots
Chest Pain
Cold/Blue hands or feet
Low Blood Pressure
Noticed Heart Racing
Shortness of Breath
Pounding Sensation
Heart Attack (Date)_____

Hair

Color Changes
Recent Loss

Ears

Buzzing
Discharges
Dizzy
Infection
Ringing
Tinnitus

Head

Concussion
Headaches
Insomnia
Memory Decline
Lack of Concentration

Mouth / Throat

Bleeding
Gum Disease
Dental Decay
Sore Throat
Toothache

Gastro-intestinal

Appendicitis
Appetite Loss
Black Stool
Blood in Stool
Constipation
Chron's
Colitis
Diarrhoea
Heart Burn
Nausea
Pain
Digestive Disorders
Gall Bladder Problem
Gas and Bloating
Irritable Bowel Syndrome
Pain after Eating
Poor Appetite
Stomach Cramps
Stomach Pain
Vomiting
Ulcers

Urinary

Bed Wetting
Bladder and Kidney Infections
Blood in Urine
Burning
Dribbling
Hesitancy
Incontinence
Infections
Kidney Stones
Yeast Infection
Decreased Force
Decreased Frequency
Increased Frequency

Vascular

Anaemia
Easy Bleeding
Easy Bruising
Haemorrhoids
Cold Hands and Feet
Leg Pain after Walking
Raynauld's
Swelling
Thromophlebitis
Varicose Veins

Musculoskeletal

Arthritis
Back Ache
Disc Problems
Fractures
Gout
Hernia
Joint Pain
Muscle Cramps
Muscle Injury
Stiffness
Paralysis
Osteoarthritis
Osteoporosis
Rheumatoid
Scoliosis

Neurological

Alzheimer's
Burning Sensation
Epilepsy
Fainting
Numbness
Parkinson's
Sciatica
Seizures
Tingling Sensation
Tremors

Endocrine

Diabetic
Hyperthyroid
Hypothyroid
Increased Thirst
Water Retention
Cold Intolerance
Heat Intolerance
Increased Sweating
Increased Urine Output

Female Reproductive

Pregnant NO
YES: Due Date_____
Birth Control Pills
Discharges
HIV
Hysterectomy
Lumps
Menopause
PMS
Regular Period
Bleeding Between Periods
Frequent Periods
Increase Flow Duration
Increase Menstrual Flow
Painful Cycle
Pelvic Inflammation
STD

Male Reproductive

Impotence
Pus Discharge
Rashes
Testicular Pain
Prostate Problems
STD
Trouble with Urination

Pain or Numbness

Shoulders
Arms
Hands
Hips
Legs
Knees
Ankles
Feet
Tail Bone
Sciatica
Swollen joints

Other

Alcoholism
Cancer
Chemotherapy
Depression
Gout
Hepatitis
Night Sweats
Steroid Therapy
Surgery
Multiple Sclerosis
Radiation Therapy
AIDS
HIV Positive
Recent Traumatic Event

Family History

Arthritis
Genetic Problems
Auto-immune Condition

Cancer
High Blood Pressure
Diabetes
High Cholesterol
Hypothyroidism
Heart Attack
Hyperthyroidism
Stroke
Vascular Problems

Childhood conditions

Measles
Mumps
Chicken Pox
Whooping Cough
Scarlet Fever
Diphtheria
Rheumatic Fever
Typhoid Fever
Ear Infections
Asthma
Allergies

Additional Information.

Medications: Are you on any medications? If so please list them.

_____
_____
_____
_____

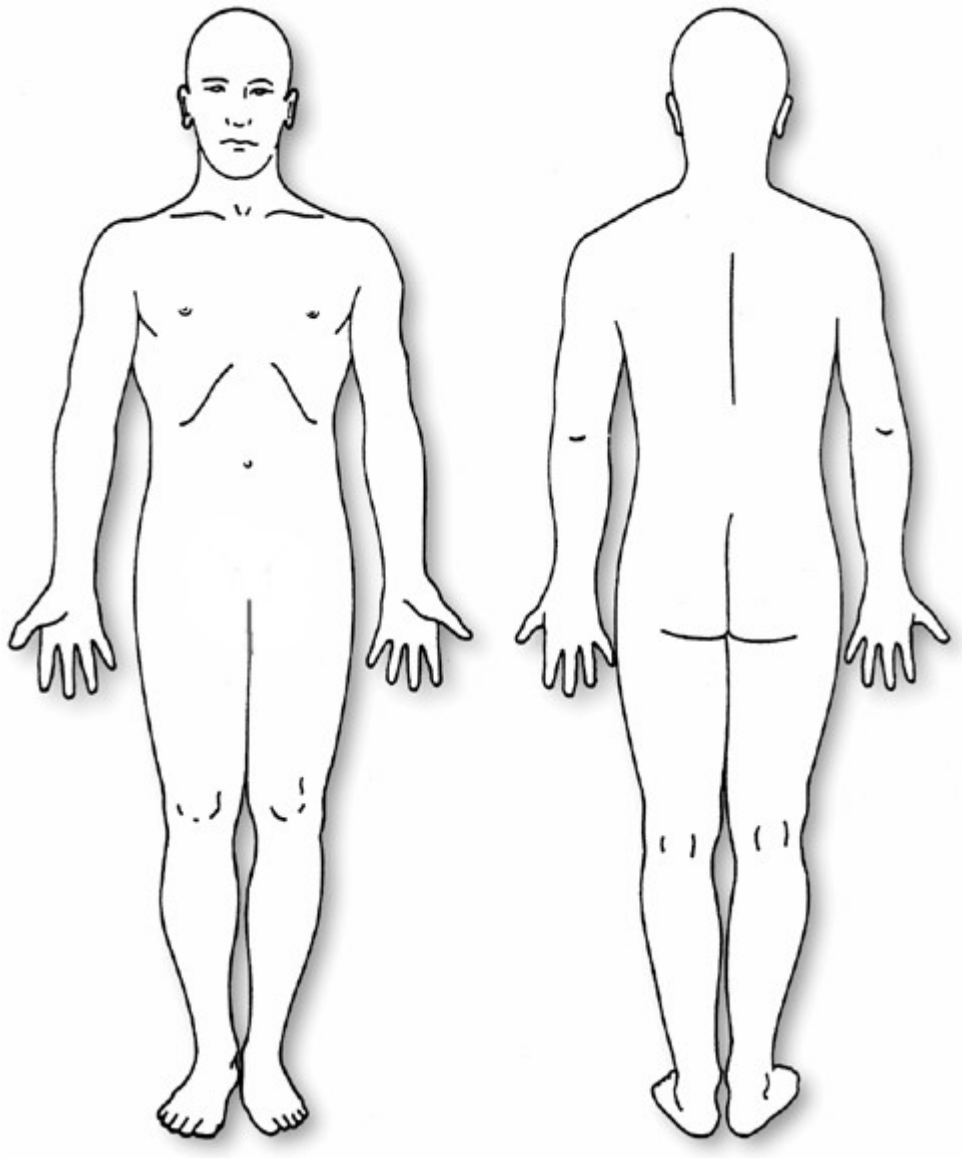
Surgeries: Have you had any previous surgeries?

_____
_____
_____
_____
_____

Other Information: Do you have any other relevant information that pertains to this case?

_____
_____
_____
_____

Pain Diagram



Please number the areas where you are experiencing pain or discomfort, according to the following pain scale.

Number Listing	Amount of pain or discomfort you are experiencing
0	No pain or discomfort.
1, 2, 3	The pain or discomfort is an annoyance.
4, 5, 6	The pain or discomfort interferes with activities.
7, 8, 9	The pain or discomfort prevents me from performing certain activities.
10	The pain or discomfort sends me to the emergency room.

Informed Consent to Massage Therapy Treatment

Dr. Brian Abelson DC. and Associates

Kinetic Health®
Soft Tissue Management Systems
Bay #10 – 34 Edgedale Dr. N.W.
Calgary, Alberta, T3A-2R4

I hereby consent for my therapist to treat me with massage therapy including such assessments, examinations, and techniques that may be recommended by my therapist.

I understand that the Massage Therapist is providing massage therapy services within their scope of practice as defined by the Massage Therapist Association of Alberta (which our practitioners are members of) and by the Province of Alberta.

I acknowledge that the therapist is not a physician and does not diagnose illness or disease or any other physical or mental disorder. I clearly understand that massage therapy is not a substitute for a medical examination, and that it is recommended that I attend my personal physician for any ailments that I may be experiencing. I acknowledge that no assurance or guarantee has been provided to me about the results of this treatment. I acknowledge that with any treatment there can be risks, that those risks have been explained to me, and I assume responsibility for those risks.

I acknowledge and understand that the therapist needs to be fully aware of my existing medical conditions. I have completed my medical history form as provided by my therapist, and have disclosed to the therapist all of those medical conditions that affect me. It is my responsibility to keep the massage therapist updated about changes to my medical history. I confirm that the information I have provided is true and complete to the best of my knowledge.

I authorize my therapist to release or obtain information that pertains to my condition(s) and/or treatment to/from my other caregivers or third-party payers.

I have read the above noted consent and I have had the opportunity to question the contents and my therapy. By signing this document, I acknowledge that I have read and understood the above statements and agree to treatment based on this document. Therefore, I intend this consent to cover the entire course of treatment for my present condition(s) and for any other conditions for which I may seek treatment in the future.

Patient Name: _____ Witness Name: _____

Patient Signature:_____ Witness Signature:_____

Date:_____ Date:_____

Kinetic Health – Massage Therapy Information

Office Hours for Massage Therapy

Monday 8 am–6 pm	Tuesday 8 am-7 pm	Wednesday 8 am–7 pm	Thursday 8 am-7 pm	Friday 8 am–6 pm	Saturday 9 am-2 pm	Sunday **Closed**

Note: Clinic will be closed all statutory holidays.

Fee Schedule

- For information about massage therapy fees, please phone our clinic at **403-241-3772**
- Payment is due upon services being rendered. We accept cash, debit, MasterCard, and Visa.

Extended Insurance

It is the patient's responsibility to confirm validity and application of extended coverage with their insurance company. Unfortunately, we DO NOT directly bill secondary insurance companies on your behalf, but we will gladly assist you with your individual insurance forms.

Motor Vehicle Accident Cases

Kinetic Health accepts MVA cases. Please notify the staff at Kinetic Health in advance or upon your first visit if your claim is to be processed through insurance for MVA. Patients are responsible for payments that are not reimbursed by MVA insurance. Ultimately, it is the patient's responsibility to pay for all costs incurred at Kinetic Health Clinic.

Contact Information

Address:

Kinetic Health®
Soft Tissue Management Systems
Bay #10 – 34 Edgedale Dr. N.W.
Calgary, Alberta, T3A-2R4

Phone: 403-241-3772

Fax: 403-241-3846

Email: kinetichealth@shaw.ca

Websites: www.kinetichealth.ca

www.releaseyourbody.com