evolve CHIROPRACTIC & WELLNESS CENTRE *

☐ Evolve 5th Avenue

Calgary Place
Suite 116, 414 - 3rd Street SW
Calgary, AB, T2P 1R2

E: 5thAve@evolvechiro.ca
T: 403.474.7792
F: 403.719.0356

☐ Evolve 8th Avenue

Watermark Tower
Suite 110, 530 - 8th Avenue SW
Calgary, AB T2P 3S8

E: 8thAve@evolvechiro.ca
T: 403.474.7792
F: 587.356.1188

Massage Therapy Intake

*denotes R Macdonald Professional Corporation

Last Name _____ First Name _____ How did you hear about us? _____

Address _____ City _____ Postal Code _____

Cell Phone _____ Work Phone _____ Emergency Contact _____ Emergency Contact Phone _____

Birthdate (dd/mm/yr) _____ Occupation _____ Email (I agree to receive appointment reminders and clinic updates) _____

EXTENDED HEALTHCARE COVERAGE

Insurance Company Name _____ Group ID/Policy Number _____ Member Number _____ Name of Cardholder _____

Main reason for appointment? _____

How is your overall health? _____

Have you had any surgeries? Date and nature: _____

Do you have any pins, wires, artificial joints/limbs? Where? _____

Have you had previous massage therapy care? ☐ Yes ☐ No

Do you currently see other practitioners? (i.e. chiro): ☐ Yes ☐ No Who? _____

Please check any health conditions that apply to you:

- ☐ heart attack
- ☐ stroke
- ☐ high blood pressure
- ☐ low circulation
- ☐ tachycardia
- ☐ bradycardia
- ☐ shortness of breath
- ☐ bronchitis
- ☐ asthma
- ☐ emphysema
- ☐ loss of sensation
- ☐ numbness
- ☐ tingling
- ☐ epilepsy
- ☐ fainting

Digestive
- ☐ constipation
- ☐ Chron's Disease
- ☐ colitis
- ☐ IBS

Head and Neck
- ☐ migraines
- ☐ headaches
- ☐ vision loss
- ☐ ear aches
- ☐ hearing loss

Muscle Stiffness
- ☐ neck
- ☐ shoulders
- ☐ back
- ☐ upper arms
- ☐ lower arms
- ☐ upper legs
- ☐ lower Legs
- ☐ hips
- ☐ hands
- ☐ feet

Women
- ☐ painful menstruation
- ☐ miscarriage
  # of pregnancies _____
  # of children _____
- ☐ other _____

Other
- ☐ arthritis
- ☐ cancer type_____
- ☐ diabetes type_____
- ☐ HIV
- ☐ TB
- ☐ hepatitis
- ☐ cold sores

Are there any other conditions not listed above? _____

I understand that the massage I receive is provided for the purpose of muscle tension, stress reduction, relief, and/or relaxation. I further understand that the 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 mental or physical ailment that I am aware of. I understand that massage therapists are not qualified to perform skeletal adjustments, diagnose and/or prescribe, and that nothing said in the course of the session should be construed as such.

Because massage is contraindicated under certain conditions, I affirm that I have stated all my known medical conditions and answered all questions honestly. I agree to keep the therapist updated as to any changes in my medical profile and understand that there shall be no liability on the therapist's part should I forget to do so.

Although minimal, I am aware of the possible side effects that massage therapy may produce including, but not limited to bruising, muscle soreness, headaches, tenderness, and fatigue.

I acknowledge I have read this consent and I have discussed or have had the opportunity to discuss the above with my massage therapist. I consent to all my present and future massages with Evolve Chiropractic and Wellness Centre.

IF I AM UNABLE TO ATTEND A SCHEDULED APPOINTMENT I WILL PROVIDE 24 HOURS NOTICE TO AVOID BEING CHARGED A MISSED APPOINTMENT FEE OF 100%. I AGREE TO PAY MY FULL ACCOUNT AT THE TIME OF EACH VISIT OR TREATMENT, INCLUDING FEES FOR SERVICE AND ANY GOODS PURCHASED.

Signature _____ Date _____