Northwest Wellness Centre

Personal Information **Date:_____**

Last Name:_____ First Name:_____ Middle Initial:_____

Date of Birth(d/m/yyyy):_____ Age:_____ ❑ Female ❑ Male

Marital Status:_____ Height(ft',in"):_____ Weight (lbs): _____

Mailing Address:_____

Postal Code:_____ Occupation:_____

Home #:_____ Work#:_____ Cell#:_____

Emergency Contact name:_____ Relationship:_____ Phone#:_____

I would like to receive reminders by ☐ Email ☐ Text Message

☐ Yes, I would like to receive occasional emails with the latest news and updates from Northwest Wellness Centre including events, new services, health tips, and promotions.

Email Address:_____ Cell Provider_____

Confidential Consent Form
for Massage Therapy

The massage therapist respects the patient's right to an informed and voluntary consent regarding care and treatment by obtaining his/her consent before providing treatment.

Your comfort and trust in the massage therapist is extremely important in providing an optimal patient/therapist relationship.

The treatment will be provided only when there is reasonable expectation that the treatment will be beneficial to the patient.

Before, during and/or after therapy, we encourage you to communicate to the therapist any aspect of the treatment in which you have concerns and/or questions.

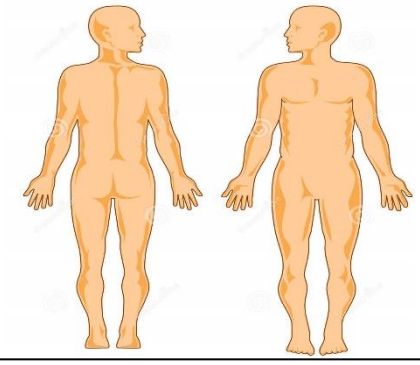
Proper draping is always provided to ensure safety, comfort and privacy for all patients. Patients will be asked to disrobe in private and prepare themselves on the massage table. You may choose to remove or leave on clothing, according to your comfort level.

I understand that my massage therapist in *not* a physician and *cannot* diagnose or prescribe towards any medical conditions or disease. I understand that it is my responsibility to notify the therapist of any changes in my health or medical history. I understand that it is ultimately my responsibility to notify the massage therapist if I am ever in any discomfort or pain. I understand that any soreness or adverse medical condition incurred during my massage will be at my fault alone. I hereby state that I have read the information above and have provided all notable information to the best of my knowledge.

I, _____ (print name) have read and understand my rights and consent to this, as well as, future treatments.

Signature: _____ Date :_____

Indicate the location of your pain by shaping in the appropriate area.



Indicate the severity of pain by circling a number
1 2 3 4 5 6 7 8 9 10
No Pain Extreme Pain

Health Questionnaire

Comments:_____

_____

_____

_____

_____

Are you taking medication? If so for what reason?

_____

_____

_____

Have you ever been diagnosed or told you have any of the following?

1. High Blood Pressure ❑Yes ❑ No
2. Heart Trouble ❑Yes ❑No
3. Varicose Veins ❑Yes ❑No
4. Rheumatic Fever ❑Yes ❑No
5. Kidney/Bladder Trouble ❑Yes ❑No
6. Gall Bladder/Liver Trouble ❑Yes ❑No
7. Stomach Ulcer ❑Yes ❑No
8. Nausea or Vomiting ❑Yes ❑No
9. Sinus Trouble ❑Yes ❑No
10. Lung Trouble ❑Yes ❑No
11. Shortness of Breath ❑Yes ❑No
12. Anemia ❑Yes ❑No
13. Unusual Weight Loss ❑Yes ❑No
14. Diabetes ❑Yes ❑No
15. Tuberculosis ❑Yes ❑No
16. Cancer/Tumor ❑Yes ❑No
17. Stroke ❑Yes ❑No
18. Epilepsy ❑Yes ❑No
19. Allergies ❑Yes ❑No
20. Skin Rash ❑Yes ❑No
21. Rheumatism/Arthritis ❑Yes ❑No
22. Rupture/Hernia ❑Yes ❑No
23. Trouble Sleeping ❑Yes ❑No
24. Fainting/Dizzy Spells ❑Yes ❑No
25. Numbness/Tingling ❑Yes ❑No
26. Weakness in Arms or Legs ❑Yes ❑No
27. Cramps or Spasm ❑Yes ❑No
28. Swelling/Inflammation ❑Yes ❑No
29. Dislocation of Joints ❑Yes ❑No
30. Broken Bones ❑Yes ❑No
31. Back/Neck Pain ❑Yes ❑No
32. Chest Pain ❑Yes ❑No
33. Back/Neck Injury ❑Yes ❑No
34. Arm/Leg Injury ❑Yes ❑No
35. Head Injury ❑Yes ❑No
36. Nervous Disorder ❑Yes ❑No
37. Severe Headaches ❑Yes ❑No
38. Hard of Hearing ❑Yes ❑No
39. Eye Trouble ❑Yes ❑No
40. Ear Trouble ❑Yes ❑No
41. Jaw Noises or Pain ❑Yes ❑No
42. Knocked out/Unconscious ❑Yes ❑No

Please Remark On all Yes Answers:_____

_____

Females: Date of last menstrual period:_____ Are you pregnant now:_____
How many children do you have:_____
**Please inform us if you become pregnant or plan to become pregnant*

What type of massage atmosphere do you prefer? Silent □ Minimal Talking □ No Preference □
What type of massage are you looking for? Relaxation □ Deep tissue □ No Preference □

Northwest Wellness Centre
Massage Fee Schedule

Visit Charges

30 minutes	$70
45 minutes	$80
60minutes	$95
90 minutes	$130-$140 (subject to practioner)

Legal Reports and insurance forms are subject to a fee.

Our office will bill directly, on the patient`s behalf of **Alberta Blue Cross, Alberta School Employee Benefit Plan, Greenshield, SSQ Insurance, RCMP, VETS (Medavie), Sun life, Canada Life, Manulife, Maximum benefit, Group Health, Group Source, Chamber of Commerce, First Canadian, CINUP, Claim Secure, Telus Adjudicare, Industrial Alliance, Johnson Inc., and other insurance companies**.. Please check with your health care provider for massage therapy coverage as individual insurance policies may vary. The Wellness Centre is not WCB authorized.

We understand that there will be circumstances for which you may not be able to keep your appointment; we require 24 hours notice for cancelation or you will be charged half of your appointment fee.

Consent

I have read the above and understand and agree that all services rendered to me are charged directly to me and I am personally responsible for payment.

Signature:_____ Date: _____