MASSAGE THERAPY FORM *PRINT *FILL OUT *BRING TO CLINIC FOR YOUR FIRST APPOINTMENT

If you have been in a Motor Vehicle accident, please call us for direction on treatments.

File #_____

MYO CENTRE INC. 13506 – 127 Street NW Edmonton, AB T5L 1B9 PH: 780 451-9290
Massage Therapy and TCM Acupuncture

Massage Therapy Intake Form

Name……Date of Birth……

Address……City……Postal Code……..

Phone …… Email……..

Family Doctor…… Occupation……

Medications……

Other treatments undergoing……

Please circle all conditions that apply to you

Headaches / Migraines	Chronic pain	Fatigue
Vision problems	Muscle or joint pain	Tension or stress / PTSD
Hearing problems	Muscle or bone injuries	Depression or Anxiety
Injuries to face or head	Numbness or tingling	Sleeping difficulties
Sinus problems	Sprains Strains	Allergies **LIST PLEASE** ……
Dental bridges/braces	Arthritis Tendonitis	Rash Athletes foot
Jaw pain TMJ	Cancer Tumors	Infectious disease
Asthma, lung condition	Spinal column disorder	Blood clots
Constipation Diarrhea	Diabetes	Varicose veins
Hernia	Pregnancy	High / low blood pressure
Birth Control IUD	Heart Circulation	Abdominal Pain

Other medical conditions not listed

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Have you received Massage Therapy before? YES / NO When? ……

Do you exercise? YES / NO Do you drink water? YES / NO Is your diet balanced? YES / NO

What is your current exercise or activity?……

Present concern you would like addressed **……**

Is this the result of an injury or accident? **……..**

Please circle your level of pain today (mild) 1 2 3 4 5 6 7 8 9 10 (severe)

PERMISSION TO TOUCH. Please be advised that our therapies often include the exposure and touching of the inner thigh, buttocks region, chest (including partial breast tissue), abdominal region, and inside of the mouth (with gloved hand, if TMJ work is required). **We never** expose or touch nipple area, genitalia, or anal area. We respect your decision to have massage therapy and/or acupuncture as part of your health maintenance program and strive to keep you safe and comfortable.

Please give a **24 hour notice for ALL CANCELLATIONS** so we can fill that empty spot. It is our Policy to **CHARGE 50%** of your booked treatment if you do not give us the fore mentioned notice.

We offer **EMAIL REMINDERS** only of your appointments direct to your PC or Smart Phone

Please **CANCEL** appointments **ONLINE or Call** 780 451-9290 during reception hours or leave a message.

Permission to contact you? **Yes** ☐ **No** ☐

I, the undersigned, hereby certify that all the information on this form is complete and accurate. I agree to pay MYO CENTRE INC. all outstanding monies owing for massage treatments received at the above mentioned clinic, should my insurance company not pay within 90 days of the original invoice date. I give my permission to receive massage therapy. I have read the above information and agree to its conditions.

Signature……..Date……

DIRECT BILLING

If you have insurance coverage for these treatments, please bring your insurance information to the clinic. Contact your insurance company first and find out what your coverage is, can you assign benefits to your practitioner and do you need a doctor's referral? We direct bill whenever possible and work to make this process as easy for you as we can.