Massage Admittance Form

Kinetic Health Massage

Bay #10 – 34 Edgedale Drive NW
Calgary, Alberta, T3A-2R4

Phone: 403-241-3772

Fax: 403-241-3846

Email:
kinetichealth@shaw.ca
Websites:
www.kinetichealth.ca
www.activerelease.ca
www.releaseyourbody.com

Date:_____

Contact Information

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

Home Address: _____

City / Province _____ Postal Code:_____

Phone (h):_____ Phone (w): _____Phone (c): _____

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 Email 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.

Your Details

Sex: ☐ Male ☐ Female Occupation: _____

Date of Birth:_____ Age: _____

Marital Status:_____ Spouse: _____

Insurance Information

Insurance Company:_____ Policy Holder's Name: _____

Blue Cross	**All Other Insurance Companies**
ID #:	**Policy #:**
Group #:	**Member ID #:**

I _____ authorize Kinetic Health to submit my claims
(Name of Policy Holder) information electronically, on behalf of myself, or for

_____. _____ _____
Name of Child or Spouse) *(Date)* *(Signature)*

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

How did you hear about us at Kinetic Health?

Emergency Contacts

Who should we contact if there is an emergency?

Name:

_____

Phone:

_____

Health Information

Family Doctor:

_____

Phone:

_____

Chief Complaints

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

- 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

Check 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
- ☐ Dryness
- ☐ Eczema
- ☐ Fungal Infection
- ☐ Herpetic Infection
- ☐ Itching
- ☐ Lumps
- ☐ Pain
- ☐ Polyps
- ☐ Psoriasis
- ☐ Rashes
- ☐ Scars
- ☐ Shingles
- ☐ Steroid Therapy
- ☐ Swelling

Vision

- ☐ Blurred Vision
- ☐ Cataracts
- ☐ Double Vision
- ☐ Dyslexia
- ☐ Glaucoma
- ☐ Light Sensitivity
- ☐ Redness
- ☐ Tearing

Cardiovascular

- ☐ Angina
- ☐ Ankle swelling
- ☐ Arrhythmia's
- ☐ Arteriosclerosis
- ☐ Blood Clots
- ☐ Chest pain
- ☐ Cold/ blue hands, feet
- ☐ Heart Attack
- ☐ High Blood Pressure
- ☐ Low Blood Pressure
- ☐ Noticed heart racing
- ☐ Pounding Sensation
- ☐ Rheumatic
- ☐ Shortness of breath

Hair

- ☐ Color Changes
- ☐ Recent Loss

Ears

- ☐ Buzzing
- ☐ Discharges
- ☐ Dizzy
- ☐ Infection
- ☐ Ringing
- ☐ Tinnitus

Head

- ☐ Concentration
- ☐ Concussion
- ☐ Headaches
- ☐ Insomnia
- ☐ Memory Decline

Mouth/Throat

- ☐ Bleeding
- ☐ Gum Disease Dental Decay
- ☐ Sore Throat
- ☐ Toothache

Gastro-intestinal

- ☐ Appendicitis
- ☐ Appetite loss
- ☐ Black Stool
- ☐ Blood in Stool
- ☐ Colitis
- ☐ Constipation
- ☐ Crohn's Disease
- ☐ Diarrhea
- ☐ Digestive Disorders
- ☐ Gall Bladder Problem
- ☐ Gas and Bloating
- ☐ Heart Burn
- ☐ Irritable Bowel Syndrome
- ☐ Nausea
- ☐ Pain
- ☐ Pain after Eating
- ☐ Poor appetite
- ☐ Stomach Cramps
- ☐ Stomach pain when upset
- ☐ Ulcers
- ☐ Vomiting

Urinary

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

Vascular

- ☐ Anemia
- ☐ Cold Hands and Feet
- ☐ Easy Bleeding
- ☐ Easy Bruising
- ☐ Hemorrhoids
- ☐ Leg pain after walking
- ☐ Raynaud's Disease
- ☐ Swelling
- ☐ Thrombophlebitis
- ☐ Varicose Veins

Musculoskeletal

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

Neurological

- ☐ Alzheimer's
- ☐ Burning sensation
- ☐ Epilepsy
- ☐ Fainting
- ☐ Numbness
- ☐ Parkinson's
- ☐ Sciatica
- ☐ Seizures
- ☐ Tingling sensation

☐ Tremors

Endocrine

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

Female Reproductive

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

Male Reproductive

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

Pain or Numbness

☐ Ankles
☐ Arms
☐ Feet
☐ Hands
☐ Hips
☐ Knees
☐ Legs
☐ Sciatica
☐ Shoulders
☐ Swollen Joints
☐ Tail bone

Other Conditions

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

Family History

☐ Arthritis
☐ Auto immune condition
☐ Cancer
☐ Diabetes
☐ Genetic Problems
☐ Heart Attack
☐ High Blood Pressure
☐ High Cholesterol
☐ Hyperthyroidism
☐ Hypothyroidism
☐ Stroke
☐ Vascular Problems

Childhood Conditions

Check all the conditions that you have ever had during your life:

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

Other_____

Additional Information.

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

_____

_____

Surgeries: Have you had any previous surgeries?

_____

_____

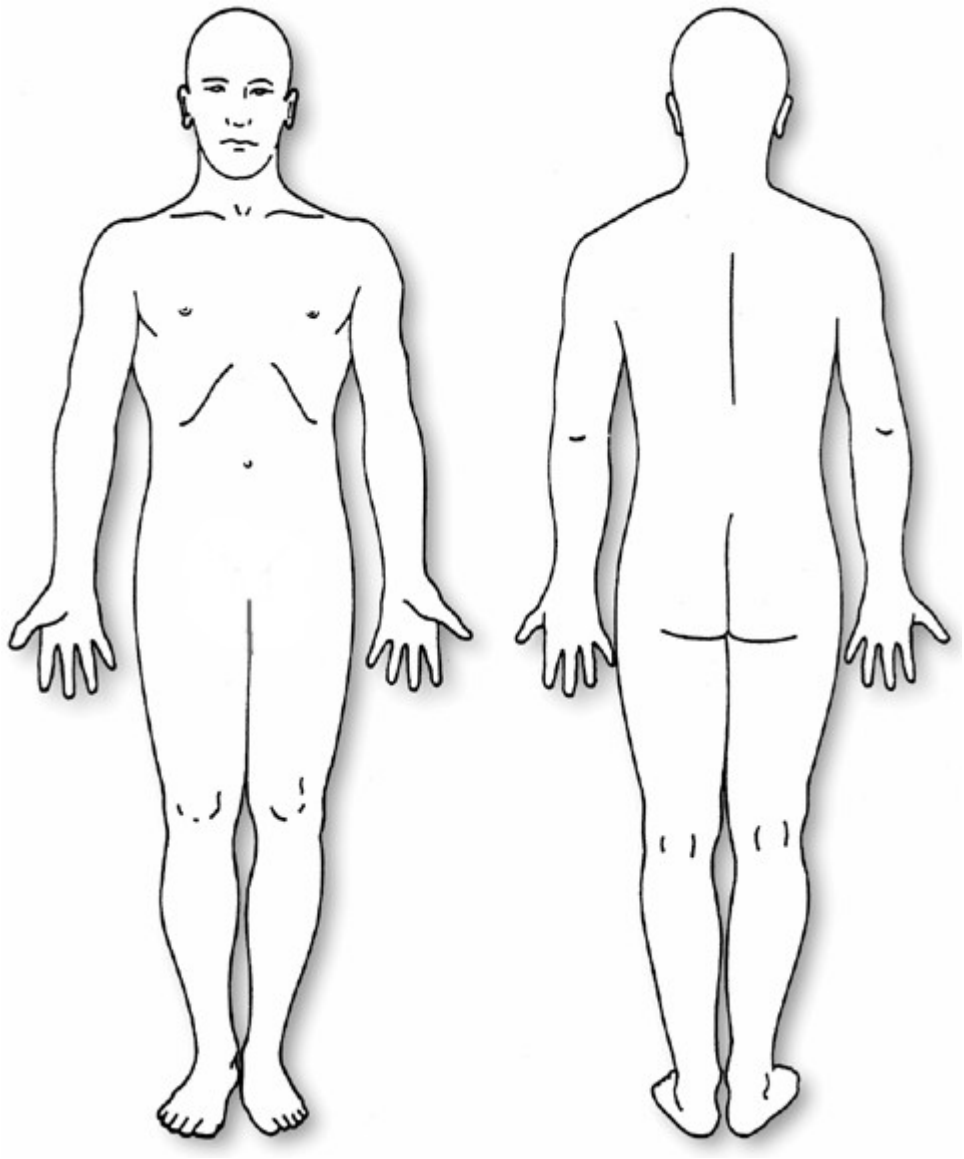
Other Information: Do you have any other relevant information that pertains to this case?

_____

_____

_____

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.

> **Note**: We are musculoskeletal practitioners (MSK) and do not directly treat conditions such as cancer, infections, or auto-immune conditions. If you have such conditions, be sure to follow the advice of your medical practitioners.

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 that 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 Information

Office Hours

Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday
9:00 AM to 6:30 PM	8:00 AM to 5:00 PM	8:00 AM to 7:00 PM	8:00 AM to 7:00 PM	8:00 AM to 5:00 PM	10:00 AM to Closing	Closed

Note: Clinic will be closed on all statutory holidays.

Fee Schedule

- For information about specific fees, please phone our clinic at **403-241-3772.**
- Payment is due upon services being rendered. We kindly accept cash, debit card, MasterCard, or Visa.
- In ALL Cases: Patients are responsible for any payments that are not reimbursed by their insurance. Ultimately, it is the patient's responsibility to pay for all costs incurred at Kinetic Health Clinic.

Extended Health Insurance

(We Submit Claims from Most Health Policies)

Both TELUS Health and BlueCross Health Care now offer a secure system that links us directly to your health care insurance, and allows us to submit your treatment claims directly to your insurance company. We, at Kinetic Health, are happy to submit insurance claims on your behalf - immediately after your payment has been processed by Kinetic Health.

All we need from you is some basic information, along with your authorization, so that we can set up the *Direct Claims Submissions* on your behalf. Here is the simple process:

1. Provide your insurance information to Kinetic Health.
2. Sign to authorize and allow Kinetic Health to submit a claim on your behalf.
3. Immediately after your treatment, pay for your treatment at the front desk.
4. We submit your claims information directly to your insurance company via a secure system.
5. Within one to three weeks (in most cases) your insurance company will either mail you a cheque, or deposit the claim amount directly into your bank account (depending on the arrangements you have made with your insurance company).

The amount of reimbursement you receive is dependent on your insurance coverage. Many insurance plans cover a set amount per year for Chiropractic and Massage treatments, while others cover a percentage of treatment (80% to 100% of treatment costs). It is well worth registering for this process, as the claim is quickly processed, and the money is soon back in your pocket!

Motor Vehicle Accident Cases

Kinetic Health accepts MVA cases. Please be sure to notify the staff at Kinetic Health in advance if your claim is to be processed through MVA insurance.

Worker's Compensations Board

Kinetic Health accepts WCB cases. If your claim is to be processed through WCB insurance, please notify the staff at Kinetic Health in advance.

Contact Information

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Web Sites: www.kinetichealth.ca / www.releaseyourbody.com