



inBalance Wellness Care Patient Intake Form

by filling out this form, it enables us to provide you with the most effective care. Thank you.
(48 HOUR CANCELLATION POLICY APPLIES; 100% OF APPLICABLE FEE PAYABLE)

ICBC MSP (Income Assist.)

Full Name: Goes by:

(LAST NAME) (FIRST NAME)

Date of Birth (mm/dd/yyyy): Marital Status: S/M/D/W

CARE CARD NUMBER (PHN):

Name of Spouse/Partner: Children, if any, and ages:

Full address with city and postal code:

Phone Nos. OK to call you at work? ____
Main: Cell: Work:

Email: Occupation and Place of work (company):

Family Dr's Name (GP): Family Dr. contact: Emergency Contact & Relation:

Is your condition an ICBC or WCB claim? If YES, please provide the information below:
CLAIM NO. Adjuster Name & Tel.

Lawyer Info (including contact number):

Where did you hear about our clinic?
Newspaper ____ Internet ____ Friend/Family ____ Other ____ GP ____

MAIN HEALTH CONCERNS (describe injury, history, etc.):

LIST ALL MAJOR INJURIES/ILLNESSES/ACCIDENTS/SURGERIES (indicate dates and nature of each)

FAMILY MEDICAL HISTORY:

Allergies		Cancer		Diabetes		Hepatitis	
Seizures		Heart Disease		Stroke		Venereal Disease	
Thyroid Disease		Varicose Veins		Rheumatic Fever		High/Low BP	

Have you tried ANY of these prior to this appt?

Acupuncture ___ Massage ___ Physiotherapy ___ Chiropractic ___ Laser therapy ___

MEDICATIONS : List all Prescription drugs _____

Over-the-counter: Anti-inflammatory ___ Pain killers ___ Muscle Relaxants ___ Sleeping pills ___ Laxatives ___

Anti-depressants ___ Supplements (e.g., ginkgo, vitamins, etc) _____

PATIENT CONSENT:

Your registered massage therapist (RMT) will make every effort to ensure that your treatment is safe and effective. At any time before or during therapy you have the right to ask that the treatment, or portions of the treatment be discontinued, or inquire about the purposes of any technique being used. If at any time you have questions or concerns related to the treatment, we encourage you to communicate with your therapist so there is clarification or modification of the treatment.

Your appointment time has been reserved for you. In courtesy of your therapist and fellow patients, we ask that you provide **us with 48 hours notice of cancellation, or a cancellation fee will be charged.** Payment for all treatment, whether private or insured, is ultimately the responsibility of the patient.

I authorize the clinic and its associated RMTs to collect my personal and medical information as documented above in order to contact me, and give permission for the clinic to leave messages regarding appointments at any of the contact numbers I have provided above. In addition, I authorize the clinic and its associated RMTs to communicate with my MD and other health care practitioners as deemed necessary for my beneficial treatment. I also understand that my personal and medical information is confidential and will only be disclosed to third parties with my permission.

Signature _____ Date _____