inBalance Wellness Care Patient Intake Form

by filling out this form, it enables us to provide you with the most effective care. Thank you.
(24 HOUR CANCELLATION POLICY APPLIES; 50% OF APPLICABLE FEE PAYABLE)

inBalance WELLNESS CARE

ICBC ☐ **MSP (Income Assist.)** ☐

Full Name: (LAST NAME) (FIRST NAME)	**Goes by:**
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 postal code:	

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

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., gingko, 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 24 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 _____