Marda Loop Naturopathic and Wellness Clinic

Osteopathic Manual Therapy / Massage Therapy Intake Form

Date _____

Name _____

Address _____

City _____ Postal Code _____

Best phone number to reach you at _____ (h) (c) (b)

Alternate phone number (optional) _____ (h) (c) (b)

E-mail _____

Date of Birth _____

Emergency Contact Name _____

Emergency Contact Phone Number _____

Emergency Contact Relation to You _____

Leisure Activities _____

How did you hear about me? _____

What are your main health concerns/reasons for visit, in order of importance?

_____

_____

_____

List any surgeries, broken bones, major injuries/illness and year they occurred.

_____

_____

_____

List any medications you are taking.

_____

_____

_____

This is a confidential record of your medical history. Information contained in it will not be released to any person unless your authorization has been given to do so.

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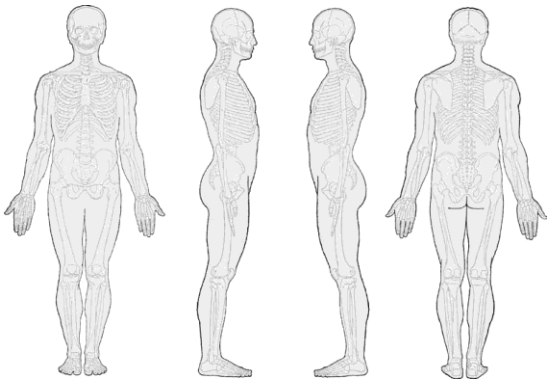
Please mark areas of pain, stiffness or discomfort on the diagram below:



Consent to Treat:

I have informed Laurie of all known physical and medical conditions and will provide updated information if my health condition is to change in the future.

I am aware that along with the many benefits of treatment, there is also a small risk of injury associated with treatment. I will discuss these benefits and risks as well as the nature of the treatment and the conditions that will be addressed with Laurie. I will be given the opportunity to ask questions and receive answers regarding the treatment.

I consent to the treatments offered or recommended to me by Laurie and intend this consent to apply to all my present and future care with Laurie.

Cancellation Policy:

In the event that I cannot keep my scheduled appointment, I agree to contact the clinic at least 48 hours prior to my appointment time.

I am aware that when I book an appointment, that time is set-aside for me. I understand that missed appointments impact not only myself and Laurie, but also other clients who may have needed that time. Because of this, if I do not attend an appointment and have not given the required notice, I agree to pay up to 100% of the cost of treatment as a cancellation fee.

Patient Signature (or legal guardian): _____ Date: _____