



WELCOME TO MASSAGE THERAPY NIAGARA

○ Newton Huynh D.C.

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New Patient Intake Form

* Please complete the forms before your first appointment. To ensure optimal care please complete the forms as accurately and detailed as possible. **All Information is Confidential.**

Patient Information		Date: DD/MM/YYYY	
First Name:		Last Name:	
Birth Date: DD/MM/YYYY	Age:	Gender:	

Contact Information		
Address:	City and Prov:	Postal Code:
Contact Phone #:		
E-Mail Address:		
Occupation:	Employer:	
Emergency Contact:	Contact Number:	

How Did You Hear About Us? (Internet, Social Media, Advertisement, Friend, etc.) Please list below:

Physician Contact	Do we have your permission to send updates and reports to your family doctor? <input type="checkbox"/> Yes <input type="checkbox"/> No
Primary Physician:	
Address:	
Phone:	

Guardian (Please complete if under 16 years of age)			
Name:		Relationship to Patient:	
Age:	Contact Number:	E-Mail:	
Address:	City and Prov:	Postal Code:	
Consent to initial physical and history examination (please circle):		YES	NO
Guardian Signature:			

Patient Medical History

Age:	Height:	Weight:
Alcohol Use: YES NO	If YES, how frequent?	
Quantity of drinks per sitting?		
Smoking: YES NO	If YES, how many smokes per day?	

Current Medical Conditions (Diabetes, high/low blood pressure, depression, anemia, etc.):

Past Medical History & Surgeries (i.e. Fibromyalgia, Rheumatoid Arthritis, anemia, bone fractures, herniated discs etc.):

List Current Medications (Name and what its prescribed for):
Current Natural Supplements (Vitamins, Minerals, Herbs):
List Allergies:
Date of last Physical Exam:

General:				
Loss of Sleep	Night Sweats	Unanticipated Weight Loss	Changes in Bowel Bladder Movements	

Cardiovascular:				
Chest Pain	Shortness of Breath	Blood Pressure (High/Low)	Irregular Heartbeat	
Heart Problems	Lung Problems/ Congestion	Varicose Veins	Extremities Swelling	
Others:				

Females Only:				
Menstrual Irregularity	Menstrual Cramping	Vaginal Pain/Infections	Breast Pain/Lumps	
Date of Last Period:		Are You Pregnant? YES NO		
Males Only:		Sexual Dysfunction	Prostate Exam Date:	
Family History (Identify any past or present health conditions such as cancer, diabetes, high blood pressure, etc.):				

Musculoskeletal:				
Low Back Pain	Neck Pain	Mid Back Pain	Arm Pain	Leg Pain
Joint Pain (Identify Joint):				

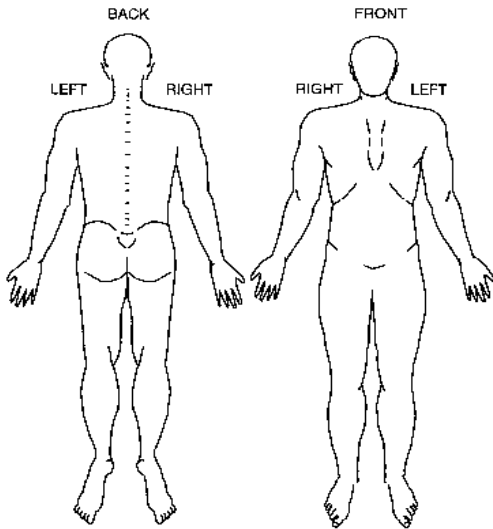
Headaches (if you have headaches please answer the following)				Date Headaches Started:	
Severity:	Mild	Moderate	Severe	Worst Headache Ever	
Frequency:	Monthly	Weekly	Daily	Intermittent	
Characteristics:	Pressure	Stabbing	Burning	Throbbing	
	Dull Ache	Tight Band	Others:		
Location (Identify where you feel the headaches):					
Nervous System:					
Numbness	Confusion	Forgetfulness	Dizziness	Fainting	
Convulsion	Paralysis/ Weakness	Decreased Sensation	Cold/Tingling Extremities		

Present Complaint (PLEASE FILL OUT) Is this an MVA case? Yes, or a WSIB case? Yes Claim #: _____

Reason for today's visit:
When did your symptoms begin (List date if possible)?
How did symptoms start? <input type="checkbox"/> Suddenly <input type="checkbox"/> Gradually over time
Do you remember doing something that started the symptoms? If yes, please describe:
Has your symptoms changed since it started? <input type="checkbox"/> No Changes <input type="checkbox"/> Improved <input type="checkbox"/> Worsened

Have you had these symptoms before? YES NO If yes, describe:
What makes the symptoms worse?
What makes the symptoms better?
Are you taking medication for the symptoms? YES NO If yes, what medication and how often?:
When are symptoms the worst? <input type="checkbox"/> Morning <input type="checkbox"/> Afternoon <input type="checkbox"/> Evening <input type="checkbox"/> Constant
Have you had imaging done (X-Ray, MRI, etc)? Location/Dates:
Do you have difficulty sleeping because of symptoms: YES NO If yes, how often?:
Any other comments or information the Chiropractor should know before seeing you?

Please mark the area of symptoms and indicate the type of symptoms: **A**= Ache, **B**= Burning, **N**= Numbness, **P**= Pins & Needles, **S**= Stabbing, **O**= Others



Please rate the following, 0 = No Pain 10 = Worst pain imaginable

What is your **average** pain level?

0	1	2	3	4	5	6	7	8	9	10
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At **worst**, my symptoms are:

0	1	2	3	4	5	6	7	8	9	10
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At **best**, my symptoms are:

0	1	2	3	4	5	6	7	8	9	10
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Right **now**, my symptoms are:

0	1	2	3	4	5	6	7	8	9	10
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CONSENT TO CHIROPRACTIC EXAMINATION

The risks associated with a chiropractic examination include, but are not limited to, short term aggravation of symptoms or muscle and ligament strains or sprains, and disc injuries. Although rare, rib fractures have been known to occur. The most common reactions to a chiropractic examination, if any, are muscle soreness and/or an increase in symptoms.

If you are not comfortable, you may stop examination at any time. Please be involved in and responsible for your care. Inform your chiropractor immediately of any change in your condition. I hereby consent to the chiropractic examination.

_____ Date: _____ 20____.
Name (Please Print)

_____ Date: _____ 20____.
Signature of patient (or legal guardian)

_____ Date: _____ 20____.
Signature of Chiropractor

Direct Billing Policy

We offer direct billing to select insurance companies for your health care provided at Massage Therapy Niagara. This is not a mandatory service but a **courtesy to our clients**. We will try to directly bill only to those companies that may allow for it and for those policies that will pay the health care provider directly. If your insurance company/policy does not pay the provider directly then we will issue you a receipt on payment for you to submit to insurance yourself.

Direct Billing Consent, Authorization and Acknowledgement

Consent to Collect and Exchange Personal Information: I authorize my health care provider to collect, use and disclose personal information concerning any claims submitted on my behalf with the insurer/plan administrator and their service providers for the purposes of assessing my claims, underwriting, investigating, auditing and administering the group benefits plan, including the investigation of fraud/plan abuse. I confirm I have consent from the primary insured plan member (if not myself) to collect, use and disclose any personal information about them for the same reasons as stated above.

I hereby authorize my health care provider to directly bill my insurance company on my behalf for services provided at Massage Therapy Niagara. I acknowledge that if my claim is not paid in part or whole, or is not paid directly to the health care provider, that I will pay any balance owing immediately after treatment. In some cases my credit card information may need to be saved to my customer profile (PCI compliant) so that if the health care provider needs to wait on payment details, my credit card can be charged at a later time for any balance owing.

Print name	Signature	Date
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Privacy Policy

Your health care provider is responsible for all personal information entrusted in writing, as well as all information pertaining to the client. For example, health history and on-going treatment forms. All written and verbal client information is kept private and confidential and cannot be discussed or released unless written consent is given by the client for this release of personal information or as governed by law. Files are stored on location by the owner and can only be accessed by staff.

Cancellation Policy

To better serve our clients, and to avoid a charge, **24 hours' notice is required to change or cancel** existing appointments. If you cancel within 24 hrs or no-show, the following charges will apply:

- 50% of the service fee will be charged for an initial occurrence.
- 100% of the service fee will be charged for any additional occurrence.
- if you have a gift certificate, it will be used as payment.

Without this policy, such activity can negatively affect our availability to our client base. As a courtesy, we will try to email or text message you in advance of your appointment to remind you, if you have provided that contact information. However, we are not responsible if these automated reminders are unsuccessful.

I understand the above Policies and I agree they are fair and reasonable.

Signature: _____ Date: _____

Massage Therapy Niagara- 6850 Thorold Stone Road (905) 357-7686 Patient Name: _____