South Surrey Chiropractic & Wellness
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MASSAGE PATIENT INTAKE FORM

Name Date

Date of Birth (MM/DD/YYYY) Gender

PHN (Care Card)

Address City

Province Postal Code

Home Phone Cell Phone

Email

How would you like to receive appointment reminders?

☐ Email ☐ Text (please indicate your provider: ___________________)

Would you like to receive our newsletter? ☐ Yes ☐ No

Your Occupation Your Work Phone

Work Activity ☐ Sitting ☐ Standing ☐ Manual Labor

Emergency Contact (Name) Phone

Relationship to you

How did you hear about our clinic? ☐ Website ☐ Facebook ☐ Google ☐ Newspaper

☐ Patient (Pt Name: ___________________________________) ☐ Other: ____________________

Do you have MSP coverage? ☐ Yes ☐ No ☐ Not Sure

Do you have Extended Health Insurance? ☐ Yes ☐ No

Extended Health Insurance Company Name:

Policy/Plan Number: Member ID/Certificate:

Are you the primary coverage holder? ☐ Yes ☐ No

Primary Holder's name (if different)

Primary Holder's DOB (MM/DD/YYY)

Primary Holder's relation to you ☐ Spouse ☐ Domestic Partner ☐ Parent

PRESENT COMPLAINT

Are you here because of a work-related injury? ☐ Yes ☐ No

If yes, please provide your WCB claim number______________________________

Are you here because of an auto accident? ☐ Yes ☐ No

If yes, please provide your ICBC claim number______________________________

What is your present complaint? Where do you feel the problem?

When did this condition/complaint start?

How did it start?

Have you had a similar condition before? ☐ Yes ☐ No

Current level of pain/ache (please circle one) 1 2 3 4 5 6 7 8 9 10 (0- no pain / 10- most pain)

How frequent is your problem? ☐ constant ☐ frequent ☐ occasional ☐ comes & goes

What activities aggravate your condition?

What relieves your condition?

On the body diagram, please indicate your areas of symptoms by drawing the appropriate symbols.

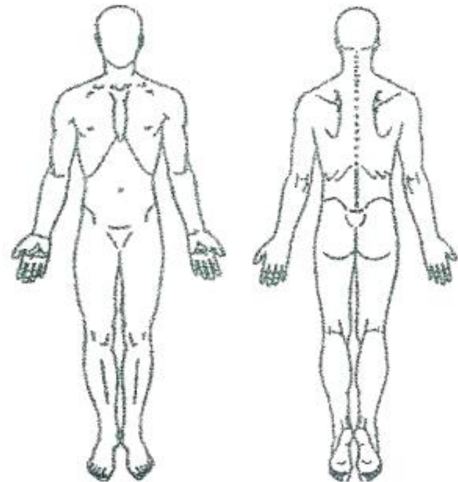
P- pain

N- numbness

W- weakness

S- shooting

A- aching



Are you pregnant? ☐ Yes ☐ No Number of Children:

Do you smoke? ☐ Yes ☐ No Do you consume alcohol? ☐ Yes ☐ No

Major Falls and/or accidents

Surgeries

Have you had any imaging done? ☐ X-rays ☐ MRI ☐ CT Scan ☐ Other ☐ No

WHEN and WHERE did you have this imaging done?

What body part?

Have you ever been knocked unconscious? ☐ Yes ☐ No

Hospitalizations

Please list any medications/supplements

Please list any allergies

FEE SCHEDULE

CHIROPRACTIC CARE

	Adult	Senior/Youth
Initial Visit	$95	$85
Subsequent Visit	$60	$55

DECOMPRESSION THERAPY & COLD LASER THERAPY

	Adult	Senior/Youth
Initial Visit	$100	$95
Subsequent Visit	$70	$65

SHOCKWAVE THERAPY

	Adult	Senior/Youth
Initial Visit	$130	$120
Subsequent Visit	$100	$90

CUSTOM ORTHOTICS

	Adult/Senior	Youth
1 Pair	$480	$350

ACUPUNCTURE CARE

Initial Visit	$120 (60 Minutes)
Subsequent Visit	$100 (45 Minutes)

*Adult: ages 18-64 *Senior: 65+ *Youth: ages 0-17

REGISTERED MASSAGE THERAPY (RMT)

Initial Visit	$120 (60 Minutes)
Subsequent Visit	$70 (30 Minutes)
	$95 (45 Minutes)
	$115 (60 Minutes)

NON-REGISTERED MASSAGE THERAPY

Initial Visit	$85 (60 Minutes)
Subsequent Visit	$55 (30 Minutes)
	$65 (45 Minutes)
	$75 (60 Minutes)

ICBC RMT APPOINTMENTS

Please note that ICBC RMT initial visits will be a 60-minute appointment at no cost. Subsequent visits will be 30 minutes also at no cost; however, patients can opt for a 45 or 60 minute subsequent RMT appointment for a small additional fee, as follows:

$7.85 (45 Minutes)

$27.85 (60 Minutes)

EXTENDED HEALTH BENEFITS

Direct Billing

AVAILABLE HERE!

CANCELLATION POLICY

Out of respect to your practitioner and other patients, 24 hours' notice is required for all cancellations. 100% of the appointment fee will be charged for appointments cancelled without 24 hours' notice. Our cancellation policy will be waived if you are unable to make your appointment due to an emergency or illness.

I understand and agree to the cancellation policy ___________ (please initial)
I consent to my file being shared if I decide to see another practitioner at SSCW ___________ (please initial)

I understand and agree to the above fee schedule. I understand that this fee schedule is not permanent and may change in the future without notice. Payment is due upon services rendered.

Patient Name (please print) **Date**

Patient Signature (or legal guardian)