

My clinic is in my home basement suite at [64 Crystalridge Close, Okotoks, T1S 1X6](#).

**Additional Important Notes:**

- Please be kid aware on the street – they can spring out of nowhere! Some are mine; many are not.

- We have a separate entrance to the basement clinic which is to the left of the house when looking at the property. Follow the stone pathway to the wooden staircase. There is no need to knock, just enter & bypass through the laundry area and down the stairs to the basement.

- The Town of Okotoks asks for my patients to park on our driveway or directly in front of our house (see image below). We just need to keep one parking bay open & available (right side when looking at the house) for my wife to be able to drive her vehicle away.



Your Muscle Health Is My #1 Priority,

Jason Barlow, RMT. P: 403 589 4645 E: [info@jasonbarlowrmt.com](mailto:info@jasonbarlowrmt.com)



| Personal Information               |             |               |   |
|------------------------------------|-------------|---------------|---|
| Name                               |             | Date of Birth |   |
| Address                            |             |               | Postal Code                                       |
| Email                              |             |               | Subscribe for discounts & insights! <i>Yes/No</i> |
| Phone                              | <i>Home</i> | <i>Work</i>   | <i>Cell</i>                                       |
| Emergency Contact                  | <i>Name</i> |               | <i>Phone</i>                                      |
| How did you hear about the clinic? |             |               |   |

| Social History      |  |                       |  |
|---------------------|--|-----------------------|--|
| Occupation          |  | Describe work duties: |  |
| Sports & Activities |  |                       |  |
| Other interests     |  |                       |  |
| Marital Status      |  | Number of Children    |  |

| Previous Care  |                               |
|--|-------------------------------|
| Have you had any accidents, injuries, or trauma in the past 5 years? | <i>Yes (details below)/No</i> |
| Have you received massage therapy care previously?                   | <i>Yes/No</i>                 |
| What areas have you had treated?                                     |                               |
| What other therapies have you received?                              |                               |

| Present Muscle Pain or Injury                    |                           |                               |   |
|--|---------------------------|-------------------------------|---|
| Area(s) of concern                               |                           |                               |   |
| What seemed to trigger the muscle pain?          |                           |                               |   |
| Pain or Tension Rating                           | <i>0-10 (10 is worst)</i> | What time of day is it worst? | <i>Morning, Afternoon, Evening, Night</i> |
| What relieves the pain or tension currently?     |                           |                               |   |
| Are you receiving any additional care presently? |                           |                               |   |



| PERSONAL MEDICAL HISTORY                  | √ | Additional Information |
|---|---|------------------------|
| Food allergies/intolerance                |   |                        |
| Digestive issues                          |   |                        |
| Fatigue/sleepiness                        |   |                        |
| Problems sleeping/insomnia                |   |                        |
| Heart disorder/heart attack/stroke/angina |   |                        |
| High Cholesterol                          |   |                        |
| Osteoporosis/Low bone density             |   |                        |
| High blood pressure                       |   |                        |
| Low blood pressure                        |   |                        |
| Diabetes                                  |   |                        |
| Hypoglycemia (low blood sugar)            |   |                        |
| High blood sugars                         |   |                        |
| Cancer                                    |   |                        |
| Thyroid problems                          |   |                        |
| Depression/anxiety                        |   |                        |
| Frequent headaches/migraines              |   |                        |
| Surgery                                   |   |                        |
| Menopause                                 |   |                        |
| Currently pregnant/breastfeeding          |   |                        |
| Lung disease/asthma                       |   |                        |
| Skin allergies/problems                   |   |                        |
| Other medical issues                      |   |                        |
| Medications                               |   |                        |

| FAMILY HISTORY                     | √ | Additional Information |
|------------------------------------|---|------------------------|
| Food allergies/intolerance         |   |                        |
| Digestive issues                   |   |                        |
| Heart disorder/heart attack/stroke |   |                        |
| High cholesterol                   |   |                        |
| Osteoporosis                       |   |                        |
| High blood pressure                |   |                        |
| Diabetes/high blood sugars         |   |                        |
| Hypoglycemia (low blood sugars)    |   |                        |
| Cancer                             |   |                        |
| Obesity/overweight                 |   |                        |
| Other medical issues               |   |                        |

### Massage Therapy & Exercise Coaching Informed Consent

I understand that massage therapy does not diagnose illness or disease, or any other disorder, and that the Massage Therapist/Exercise Coach does not prescribe medical treatments or pharmaceuticals.

I have informed the Massage Therapist/Exercise Coach of all my known physical conditions, medical conditions and medications and I will keep the Massage Therapist/Exercise Coach updated on any changes to my health history. I also understand that I should seek a physician's advice prior to any fitness training or massage therapy.

I have read, understood and completed, to the best of my knowledge, the Patient Health Questionnaire and Informed Consent Form. I acknowledge that I may suffer injury or loss as the result of participation and I hereby release Jason Barlow, RMT from any and all liability from any injuries or loss arising from the treatments.

*Patient Signature (Legal Guardian)*

|       |         |             |
|-------|---------|-------------|
| Date: | Signed: | Print Name: |
|-------|---------|-------------|

**\*\*Patients under the age of 18 to be signed by parents/guardians\*\***

I, \_\_\_\_\_, (Parent or Legal Guardian name) completely accept responsibility for my child's participation. I agree to indemnify, and save harmless, Jason Barlow, RMT from any liability and claim from any injury or loss that my child may experience as a result of the treatments.

### Fee Schedule

| Therapeutic Massage | 30-mins  | 60-mins   | 90-mins   |
|---------------------|----------|-----------|-----------|
|                     | \$65+GST | \$120+GST | \$180+GST |
| 55+ & Students      |          |           |           |
|                     | \$55+GST | \$100+GST | \$150+GST |

### Payment

Payment is due at the time of each visit by cash, debit, Visa/Mastercard or eTransfer. Direct Billing is available for most insurances. **Please email your health insurance details prior to your first visit.**

### Cancellation Policy & Missed Appointment:

- I may cancel my appointment without charge anytime before the close of business on the business day preceding my appointment.
- If I cancel on the day of my appointment, or if I do not call to cancel my appointment or fail to show for my scheduled appointment, I will be charged full price for the scheduled service.

I have read and agree to the above conditions set forth in this fee schedule.

*Patient Signature (Legal Guardian)*

|       |         |             |
|-------|---------|-------------|
| Date: | Signed: | Print Name: |
|-------|---------|-------------|



**JASON BARLOW, RMT**  
MASSAGE & LIFESTYLE