New Patient Admittance Form - Massage

PERSONAL INFORMATION

Name:_____ Emergency Contact:_____

Birthdate:_____ Emergency Phone #:_____

Address:_____ City:_____ Postal Code:_____

Phone #:(cell)_____ Email:_____

Occupation:_____

Family Doctor:_____ Phone #:_____

MEDICAL HISTORY

Please describe your current condition and symptoms: _____

_____

How did it start? _____

Describe the type of pain (circle): Sharp Excruciating Burning Dull Aching

What aggravates it? _____

What relieves it? _____

When is the pain the worst? (circle) Morning Afternoon Evening Night Constant

Are you currently taking any medications? Pain Reliever Anti-inflammatory Anti-Depressant Other:

Please list your medications: _____

Do you have any allergies? YES NO If yes, please list them: _____

_____

Are you currently receiving treatment from any of the following? (circle)

MD CHIROPRACTIC PHYSIOTHERAPY ACUPUNCTURE NATUROPATH

Have you ever had any serious injury accident or surgery? Please list type and approximate year it occurred.

_____

_____

What is the amount of stress you are subject to? (circle) High Moderate Low None

Do you engage in regular exercise? YES NO Please list the **type**, **frequency** and **duration**:

_____

Please indicate any of the following which you have experienced in the **past (P)** or **currently (C)**.

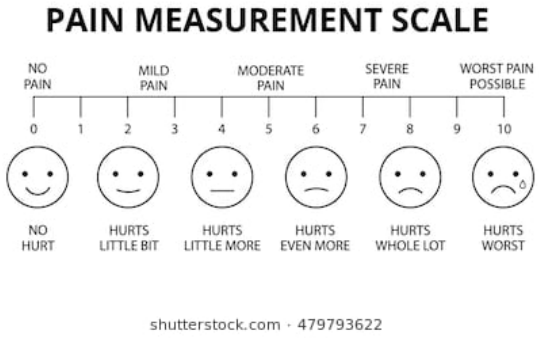
Headaches	Muscle tightness	Numbness, Tingling
Disc problem	Arthritis	Chest pain
High / Low Blood pressure	Heart condition	blood Clots
Bruise easily	Neurological condition	Pregnancy
Fatigue	Stress	Contagious Disease

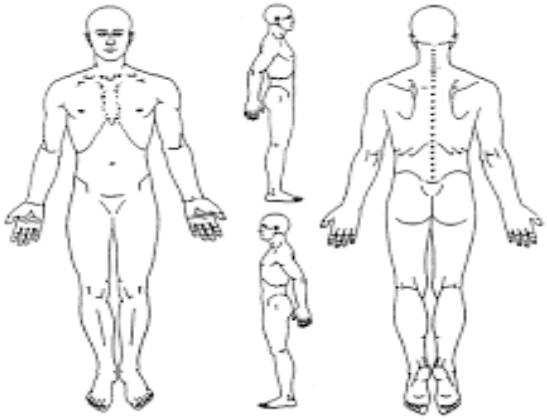
Pain in: Shoulder Arm Hand Hip Leg Foot

Pain in: Upper back Mid back Low back

Shortness of breath / Anemia / Aneurysm / HIV / AIDS / Epilepsy

Other: _____





Please indicate with X, or circle any areas of pain/ discomfort on the diagram.

CONSENT TO TREATMENT

Please be sure to ask your RMT any questions you have about this form or its contents before you sign. You have the right at any time to ask questions about your treatment. Please be sure to immediately advise your RMT if you become uncomfortable with any aspect of your treatment, so that they may stop and discuss your concern.

RISKS, COMPLICATIONS AND SIDE EFFECTS:

- There are risks associated with any manual therapy including those used by Registered Massage Therapists. Examples include bruising, aching, discomfort, short term aggravation of symptoms, muscle and ligament strains, sprains, and skin irritation.
- I do not expect the RMT to be able to anticipate and explain ALL possible risks, complications and side effects of my treatment. I have discussed any specific concerns I have about possible risks with my therapist before signing this document.
- I wish to rely on the RMT to exercise their judgement during treatment to provide the treatment that is in my best interest.

DISCLOSURE OF MEDICAL HISTORY:

- It is important for the RMT to know my medical history as it may relate to my treatments
- I have disclosed to the RMT in writing all medical conditions including any mental or emotional conditions for which I have received treatment currently affecting me and those that have affected me in the past.
- I will immediately disclose in writing any medical condition I subsequently realize I have not already disclosed including any new condition that may develop after my completion of this form

CONFIDENTIALITY:

- I authorize the clinic to collect my personal and medical information as documented for use in and consultation or treatment that I may seek from the RMT. In addition, I give permission for the clinic to leave messages regarding appointment at my home or work voicemail.
- I authorize the clinic to communicate with my referring MD as deemed necessary for my beneficial treatment.
- The contents of this form and my patient records will be kept confidential unless I have expressed or implied consent to the release of my information or where there is a legal requirement to provide my information to a third party.

NO GUARANTEE OF RESULTS

I acknowledge/confirm that no guarantee or assurance of results has been made regarding my treatments.

Signature of Patient _____ Date: _____

- MD referral is required for ICBC and WSBC claims, and some extended health plans. Please check with your extended health provider for their requirements.
- I understand that if ICBC/WSBC does not pay for my treatment, I will be responsible for the payment.
- ICBC claims are charged the full fee and you take your receipts to them for reimbursement.
- By signing below, I understand the fee structure and accept responsibility for prompt payment.
- Your appointment time has been reserved especially for you.

I require **24-hour** notice if you are unable to make your appointment as scheduled. Please call the office and reschedule if the time is inconvenient to you. There will be a **CANCELLATION FEE** for any **MISSED APPOINTMENT** or **SHORT-NOTICE CANCELLATIONS** (barring emergencies).

Signature of Patient _____ Date: _____