

CONFIDENTIAL PERSONAL HEALTH INFORMATION  
Registered Massage Therapy  
Total Body Chiropractic

Name: \_\_\_\_\_ Birth date: \_\_\_\_\_ Care Card #: \_\_\_\_\_

Address: \_\_\_\_\_ Postal Code: \_\_\_\_\_

Phone number: \_\_\_\_\_ Email: \_\_\_\_\_

Occupation: \_\_\_\_\_ Work/Life Stress Level (1 low/10 high) \_\_\_\_\_

**How did you hear about our clinic?** \_\_\_\_\_

**Previous Therapies:**  Massage Therapy  Physiotherapy  Chiropractic  Other: \_\_\_\_\_

**PLEASE CHECK ANY OF THE FOLLOWING CONDITIONS THAT APPLY TO YOU:**

- |  |   |   |  |
|--|---|---|--|
| <input type="checkbox"/> Headaches       | <input type="checkbox"/> Neck pain            | <input type="checkbox"/> Heart Condition        | <input type="checkbox"/> Plates or pins  |
| <input type="checkbox"/> Jaw pain        | <input type="checkbox"/> Arthritis            | <input type="checkbox"/> Loss of Skin Sensation | <input type="checkbox"/> Allergies       |
| <input type="checkbox"/> Upper back ache | <input type="checkbox"/> Lower back ache      | <input type="checkbox"/> Skin Disorders         | <input type="checkbox"/> Cancer          |
| <input type="checkbox"/> Numbness        | <input type="checkbox"/> Acute inflamed areas | <input type="checkbox"/> High blood pressure    | <input type="checkbox"/> Digestive Issue |
| <input type="checkbox"/> Nausea          | <input type="checkbox"/> Varicose Veins       | <input type="checkbox"/> Bruise easily          | <input type="checkbox"/> Diabetes        |
| <input type="checkbox"/> Dizziness       | <input type="checkbox"/> Pregnancy            | <input type="checkbox"/> Other: _____           |  |

**Main area(s) of discomfort:** \_\_\_\_\_

**Have you had Massage Therapy before?** \_\_\_\_\_ If so, when was your last session? \_\_\_\_\_

**What do you hope to achieve with Massage Therapy?** \_\_\_\_\_

What did you like **best** about past Massage Therapy treatments? \_\_\_\_\_

What did you like the **least** about past Massage Therapy treatments? \_\_\_\_\_

Do you like quiet during your massage or do you like to chat? (There does need to be some communication about pressure, comfort, etc., but it can be kept to a minimum.) \_\_\_\_\_

What type of pressure or depth do you like? \_\_\_\_\_

Do you exercise regularly? \_\_\_\_\_ List exercises: \_\_\_\_\_

Past major surgeries, injuries, and/or accidents: \_\_\_\_\_

Medications you are currently taking (name and what for): \_\_\_\_\_

**If you're here because you've been in a Motor Vehicle Accident, please fill out the following:**

**\* Please note: ICBC may only cover \$23 per treatment depending on the circumstances surrounding the MVA. Please check with your adjuster.\***

Physician's name: \_\_\_\_\_

ICBC Claim #: \_\_\_\_\_ Date of accident: \_\_\_\_\_

Adjuster's name: \_\_\_\_\_ Phone: \_\_\_\_\_

Lawyer's name: \_\_\_\_\_ Phone: \_\_\_\_\_

### **WCB:**

At this time we do not accept WCB claims. If your injury occurred at work or while working you may be eligible for some coverage for treatment through WCB. You will be responsible for this treatment today at our usual private rates.

### **Cancellation Policy:**

In consideration of your fellow patients and your Therapist please allow a **minimum of 24 HOURS NOTICE** to change or cancel your appointment. Therapists are independent contractors and get paid by the treatments they perform. They will not be paid if you miss your appointment. **You will be charged the full fee for late cancellations or missed appointments.** You are responsible for all fees incurred for therapy.

I authorize the clinic and its associated RMTs to collect my personal and medical information as documented above in order to contact me, and give permission for the clinic to leave messages regarding appointments at any of the contact numbers I have provided above. In addition, I authorize the clinic and its associated RMTs to communicate with my referring MD as deemed necessary for my beneficial treatment. I also understand that my personal and medical information is confidential and will only be disclosed to third parties with my permission.

**By my signature I confirm that I have read the foregoing and agree to the terms set out.**

**Patient's signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_