



Caring Hands Physiotherapy

Name: _____ Phone: _____
Address: _____
City: _____ Province: _____ Postal Code: _____
Email: _____
Date of Birth: (M/D/Y) _____ Occupation: _____
Emergency Contact: _____ Relationship: _____
Emergency Contact Phone: _____
Physicians Name: _____ Contact Number: _____

Billing & Payment

I authorize _____ to submit claims on my behalf to my insurance company and I am responsible to pay any co-payment or any outstanding balance for my Massage Services at each time. In the event my insurance company denies the payment for any reason, I would be responsible to pay for my whole session.

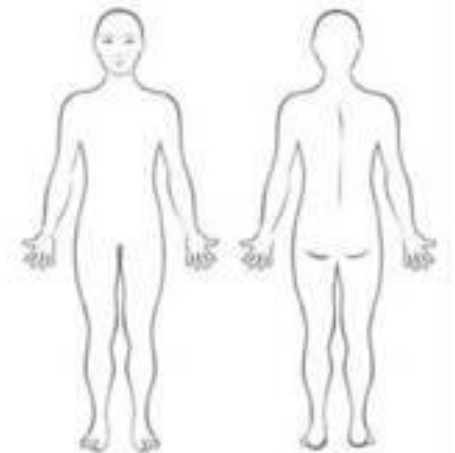
Patient/ Parent/Guardian signature: _____ **Date:** _____

If you are under 18, Parent/Guardian must sign.

The following information will be used to help plan safe and effective massage sessions.

Please answer the questions to the best of your knowledge:

1. Have you ever had a professional massage before? yes no
2. Do you have any difficulty lying on your front, back, side? yes no
If yes, please explain _____
3. Do you have any allergies to oils, lotions, or ointments? yes no
If yes, please explain _____
4. Do you have sensitive skin? yes no
5. Do you sit for long hours at a workstation, computer, or driving? yes no
6. Do you perform any repetitive movement in your work, sports, or hobby? yes no
If yes, please describe _____
7. Do you experience stress in your work, family, or other aspects of your life? yes no
If yes, how do you think it has affected your health?
 muscle tension anxiety insomnia irritability other _____
8. Is there a particular area of the body where you are experiencing tension, stiffness, pain, or other discomfort? yes no
If yes, please identify _____
9. Do you have any goals in mind for this massage session?
yes no
10. Circle any specific areas you would like the massage therapist to concentrate on during



Continue Back.....

MEDICAL HISTORY

To plan a massage session that is safe and effective, we need some general information about your medical history.

11. Are you currently under medical supervision? yes no
If yes, please explain _____
12. Do you see a chiropractor? yes no
If yes, how often? _____
13. What is your primary complaint (or body part injury or pain)?

14. Please provide a list of any surgeries, past injury, or past condition you've had:

15. Is your pain related to Car accident _____ (date of MVA) Work related injury (date of injury) Other
16. Are you pregnant? Yes No Not sure. If Yes, how many weeks? _____
If Yes _____, I understand and voluntarily consent to receive massage therapy while understanding all possible risk (if any)
17. Is there anything else about your health history that you think would be useful for your massage practitioner to know? _____

Draping will be used during the session - only the area being worked on will be uncovered.

CONSENT

_____ I understand that the massage I receive is provided for the basic purpose of relaxation and relief of muscular tension. If I experience any pain or discomfort during this session, I will immediately inform the therapist so that the pressure and/or strokes may be adjusted to the level of comfort.

_____ I understand that massage therapists are not qualified to perform spinal or skeletal adjustments, diagnose, prescribe, or treat any physical or mental illness, and that nothing said during the session given should be construed as such.

_____ I affirm that I have stated all my known medical conditions and answered all questions honestly. I agree to keep the therapist updated as to any changes in my medical profile and understand that there shall be no liability on the therapist's part should I fail to do so.

_____ Sexual advances, request for sexual favours, and other verbal or physical conduct of a sexual nature will constitute as sexual harassment and will not be tolerated. Your session will be immediately terminated, and you will be responsible to pay in full for the session booked. You must then leave the premises and will be prohibited to return to the clinic in the future.

_____ Patients are responsible for providing 24 hrs notice for appointment cancellation. If you cancel without notice, 50% of the service will be charged to you directly.

Client Signature

Date

Therapist Signature

Date