body works

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All information is strictly confidential under the Provider-Patient relationship and nothing will be released unless instructed to do so by the patient.

PATIENT INFORMATION

Name: _____ Date: _____

Date of Birth: _____ Occupation:_____
(DD/MM/YYYY)

Address:_____

City: _____ Province:_____ Postal Code:_____

Home:_____ Emergency Contact: _____

Work: _____ Contact number: _____

Cell: _____ Relationship: _____

Email:_____

Medical Doctor:_____ PEI Health card no: _____

INSURANCE INFORMATION

We can bill most private health insurance plans directly.

☐ If you do NOT have insurance, please tick this box and proceed to the next section.

Insurance Provider: _____ Policy/Group/Plan number: _____

ID number: _____ If you are not the policy holder, complete below:

First & last name: _____ Date of Birth: _____

Relationship to policy holder: ☐ Spouse ☐ Child Other: _____

MEDICAL HISTORY/ INFORMATION

How did you hear about us? Where you referred by a health care practitioner? If yes, who?

_____

Personal Health Conditions (tick all that apply to you):

☐ Heart attack	☐ Spinal injury	☐ Skin condition
☐ High/low blood pressure	☐ Head injury	☐ Bone fracture
☐ Stroke or aneurysm	☐ Epilepsy/other seizures	☐ Joint dislocation
☐ Pace maker	☐ Other neurological condition	☐ Arthritis
☐ Other heart condition	☐ Irritable bowel syndrome/Colitis	☐ Osteoporosis
☐ Bruise easily	☐ Other digestive condition	☐ Dizziness/Fainting
☐ Varicose veins	☐ Corrective lenses/contacts	☐ Headaches/migraines
☐ Other circulatory condition	☐ Hepatitis/HIV/V.D.	☐ Nausea
☐ Diabetes	☐ Other contagious condition: _____	
☐ Kidney disease	☐ Cancer: _____	
☐ Other urinary condition	☐ Rods/pins/plates/shunts: _____	
☐ Implants: _____	☐ Transplant: _____	

Please list any known allergies (including medications, foods, oils and lotions, etc):

_____

List any activities, sports, hobbies (ie. running, hockey, crafts, video games, etc):

_____

List any medications/vitamins you are currently taking:_____

_____

Have you ever been hospitalized, had any major accidents, illnesses, or surgeries/operations?

If yes, please list with dates:_____

_____

Are you currently pregnant? If yes, how many weeks will you be at the time of treatment? _____

Do you:	Smoke cigarettes?	☐ Yes	☐ No	☐ Occasionally
	Consume alcohol?	☐ Yes	☐ No	☐ Occasionally
	Consume cannabis?	☐ Yes	☐ No	☐ Occasionally

CURRENT CONDITION

Please describe your current condition and symptoms: _____

_____

How & when did the problem begin? _____

_____

What aggravates it? _____

What relieves it? _____

CONSENTS

Privacy and sharing of information

I authorize the clinic and its associated health professionals to collect my personal and medical information as documented above. In addition, I authorize the clinic and its associated health professionals to communicate with my family doctor and/or referring doctor as deemed necessary for my beneficial treatment.

Cancellation policy

Your appointment time is reserved just for you. A late cancellation or missed visit leaves a gap in the therapist's day that could have been filled by another patient. Patients who provide less than 24 hours notice, or miss their appointment, will be charged a cancellation fee of 100% of the service cost.

Accuracy of information & consent to examination and treatment

I certify that the above medical information is correct to my knowledge. I hereby request and consent to receive massage therapy treatment including various forms of massage therapy, range of motion testing and orthopaedic testing. I understand that this consent is voluntary and may be revoked by me at any time. I acknowledge that I have fully disclosed any health issues relevant to the massage therapy services I am receiving today. I further understand that in the practice of massage therapy, as in all health care, there are some very slight risks to treatment, including but not limited to muscle tenderness, stiffness, and sometimes light bruising. I do not expect the RMT to be able to anticipate and explain all the risks and complications associated with soft tissue manipulations. I wish to rely on the RMT to exercise judgement during the course of my treatment(s), and to apply those treatments which they feel, based on the facts known, are in my best interests. I acknowledge that inappropriate conduct of any nature will not be tolerated and may result in the treatment being terminated.

Name: _____ **Date**: _____

Please print *DD/MM/YYYY*

Signature: _____