BURQUITLAM PHYSIOTHERAPY
PRECISIONCARE

Registered Massage Therapy Intake Form

Personal Information:

Name: *Last* _____ *First* _____ *Middle* _____ Sex: M/F

BC CareCard#: _____ Date of Birth: (mm/dd/yyyy) __/__/____ Age: ___

Home Address: *Street* _____ *City* _____

Postal Code _____ Phone: Home _____ Cell _____

Email: _____

Employer: _____ Occupation: _____ Work Phone: _____

How did you find out about us? (Please check)

( ) Signboards/ Just passed by

( ) Flyer/ Brochure

( ) Friend/ Relative:_____

( ) Doctor: _____

( ) Other: _____

ICBC Claim or Extended Healthcare Benefits:

Claim Number: _____ Date of Accident: (mm/dd/yyyy) __/__/____

Case Manager: _____ Phone: _____

O Pacific Blue Cross O Sun Life Financial O Chambers of Commerce O Desjardins O Industrial Alliance
O Johnston Group O Maximum Benefit O Great-West Life O Johnson Inc. O Manulife O GreenShield
O Cowan O RCMP O Veteran Affairs Canada
O Other :_____

Policy Number:_____

Member ID:_____

The following information will be used to help plan safe and effective massage sessions. Please answer the questions to the best of your knowledge.

What/Where is your pain/problem?

_____

Do you know what caused it?

_____

How would you rate the pain?

1 2 3 4 5 6 7 8 9 10

When did it start?

_____

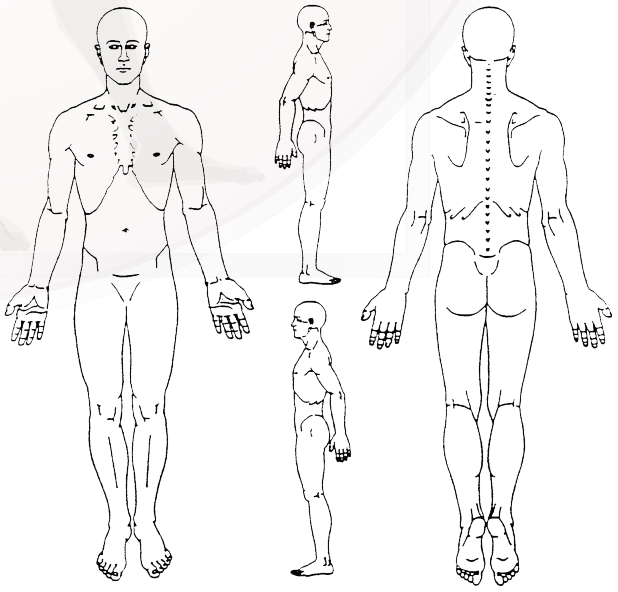
What would aggravate the pain/problem?

_____

What would relieve the pain/problem?

_____

Please circle on the diagram below



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Medical History:

In order to plan a safe and effective massage session, please provide general information about your medical history.

Do you have any allergies? If yes, please explain

_____

Are you taking any medication? If yes, please list

_____

Are you pregnant? If yes, how many months? _____

Please check any condition listed below that applies to you

__Contagious skin condition
__Open sores or wound
__Easy Bruising
__Recent accident or injury
__Recent fracture
__Artifical joint
__Sprains/strains
__Current fever
__Swollen Glands
__Allergies/sensitivity
__Heart condition
__High or low blood pressure
__Circulatory disorder
__Varicose veins
__Atherosclerosis
__Phlebitis
__Deep vein thrombosis
__Joint disorder
__Rheumatoid arthritis
__Osteoarthritis
__Tendinitis
__Osteoprorosis
__Epilepsy
__Headaches/migraines
__Cancer
__Diabetes
__Decreased sensation
__Back/neck problems
__Fibromyalgia
__TMJ dysfunction
__Carpal tunnel syndrome
__Tennis/golf elbow
__Frozen shoulder

Please list any major surgery and the year when it was performed.

_____

Is there anything else about your health history that you would like to add?

_____

Acknowledgement:

PRIVACY AND SHARING OF INFORMATION

I authorize **Burquitlam Physiotherapy (PrecisionCare)** and its associated health professionals to collect my personal and medical information as documented above. In addition, I authorize **Burquitlam Physiotherapy (PrecisionCare)** and its associated health professionals to communicate with my family physicians, specialists, case managers, adjusters 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 hole in the therapists' day that could have been filled by another patient. As such, we require 24 hours notice for any cancellations or changes to your appointment.

I understand that in the event that I fail to provide 24hrs advanced notice to cancel my appointment a cancellation fee will be imposed. This cancellation fee is in accordance with the most current fee schedule set for the therapist I would have seen.

CONSENT TO REGISTERED MASSAGE THERAPIST TREATMENT

I hereby give **Burquitlam Physiotherapy (PrecisionCare)** and all healthcare professionals working under that entity consent to treatment and will not hold these bodies responsible for the outcome of such treatment with the understanding that treating therapists and healthcare professionals will practice within their scope of practice as set forth in the Health Professions Act and within the guidelines of their respective professional governing authorities. I also understand that a typical treatment session may involve body exposure and tissue palpation for the purposes of examination and/or treatment; furthermore, a gown is always available to me, and I am not obligated to remove any article of clothing if I feel uncomfortable doing so. I am free to ask pertinent questions that relate to my condition as well as the examination process and have the right to refuse treatment at any time.

_____ _____

Client Signature (or Legal Guardian) Signature of Witness

Date: _____