**Personal \*\*\*Please Read & fill in all information in details\*\*\***

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

All the information in this section has not changed since my last visit. Please proceed to the Referral Section below.

**First Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Last Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** **Date of Birth \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

 **(Mm/dd/yy)**

**Current Address** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**City** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Province** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Postal Code:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Email Address Home Phone Alternative Phone #: Cell Work**

**Health Card No \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Gender: Male / Female**

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Emergency Contact Person Relationship Phone

**Coverage & Referral:**

Extended Health Care: (ex: Alberta Blue Cross or other)  MVA WCB  Law Firm  Self Pay

**How did you hear about us**: **** Sage Hill Community,  Google,  Radio \_\_\_\_\_\_\_\_\_  Physician \_\_\_\_\_\_\_\_\_

 Friends/Relatives (full name) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Newspaper/Magazine \_\_\_\_\_\_\_\_\_  Other \_\_\_\_\_\_\_\_\_

**Physician Details:**

Family Physician Full Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Clinic Name & Number \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Health & General Information**

**Is this your first massage?** Yes / No

What brings you in for massage? Stress/pain relief/tension/other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you know the cause of pain and how long you had the pain? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Is there something that relieves and aggravates the pain? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Have you seen your family doctor about this particular problem? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

What is your primary **complaint (or body part injury or pain)**? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Please Circle areas Complaint (if any)**



**For Prenatal Clients only - Please Fill in What Applies To You:**

I am not sure if I am pregnant  I am pregnant  This is my 1st, 2nd or \_\_\_\_\_\_\_\_ Pregnancy

 I am \_\_\_\_\_\_\_\_\_\_\_\_\_ (number) week in my \_\_\_\_\_\_\_\_\_ (1st, 2nd, 3rd) trimester

 Have you had massage before during Pregnancy? Yes / No

 Have you consult your Physician about potential benefits and risks of prenatal massage. YES / NO

**Please read the Consent for Prenatal Massage**

**Consent**

**Consent for Treatment**

**\_\_\_\_\_\_\_\_\_\_\_**I understand that Massage Therapy I receive is provided for the basic purpose of **relaxation, stress reduction and relief of muscular tension**. I further understand that Massage Therapy should not be interpreted as a substitute for medical examination, diagnosis, or treatment and if that then should consult by a physician or other qualified medical specialist for any mental or physical ailment that I am aware of.

**\_\_\_\_\_\_\_\_\_\_\_** I Understand that Massage Therapist is not qualified to perform skeletal adjustments, diagnose and/or prescribe, and that nothing in the course of the session should be interpreted as such.

\_\_\_\_\_\_\_\_\_\_ I affirm that I have stated all my medical conditions and answers to all questions honestly and to the best of my knowledge. I agree to inform my Massage therapist of any updates to my medical profile and understand that there be no liability on the therapist’s part if I either forgot or didn’t mentioned.

**Patient/Parent/Guardian Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

If you are under the age of 18, Parent/Guardian must sign

**Representative Witness Signature:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Consent for Prenatal Massage –** Please read and sign

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, I understand and voluntarily consent to receive massage therapy while understanding all possible risk (if any).

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, I verify that I have stated all my known medical conditions and risks with my massage therapist.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, I understand and have consulted my physician about any possible risks and benefits of prenatal massage therapy whether I am at low-risk/high-risk.

**Medical Records Consent**

**Release of Medical Record:**

I authorize Sage Hill Physiotherapy and Massage Centre to **Release or Request** any information from **Physicians**, **Diagnostic Centers**, **Insurance Companies, Employers, and Law Firms** with respect to my care.

**Patient/Parent/Guardian Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

If you are under the age of 18, Parent/Guardian must sign

**Billing & Payment**

**Payment for Service Acknowledgement**

I authorize Sage Hill Physiotherapy and Massage Centre 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 physiotherapy & Massage services at each time of the appointment upon arrival. In the event my insurance company denies the payment for any reason, **I would be responsible to pay for my physiotherapy & Massage services.**

**OR**

If the client **does not** carry any insurance coverage, than Client is **fully responsible** to pay the complete fee amount for his/her Physiotherapy / Massage services at each time of the appointment upon arrival.

**Patient/Parent/Guardian Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

If you are under the age of 18, Parent/Guardian must sign

**Cancellation Policy**

Please provide **24 HOURS** cancellation notice for all **Physiotherapy / Massage** appointments. We reserve the right to charge the cancellation fee for all cancelled or missed appointments without **24 Hours’** notice.

**Please note that your Insurance is not responsible to cover the cost of the cancellation fees.**

**PHYSIOTHERAPY CANCELLATION FEE: Per Session** $30

**MASSAGE CANCELLATION FEE:**  **(30 Minutes --- $25) (45 Minutes --- $32) (60 Minutes ---$40) (90 Minutes --- $60)**

**I have read, understood and agreed to the cancellation policy as stated above.**



**Patient/Parent/Guardian Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**