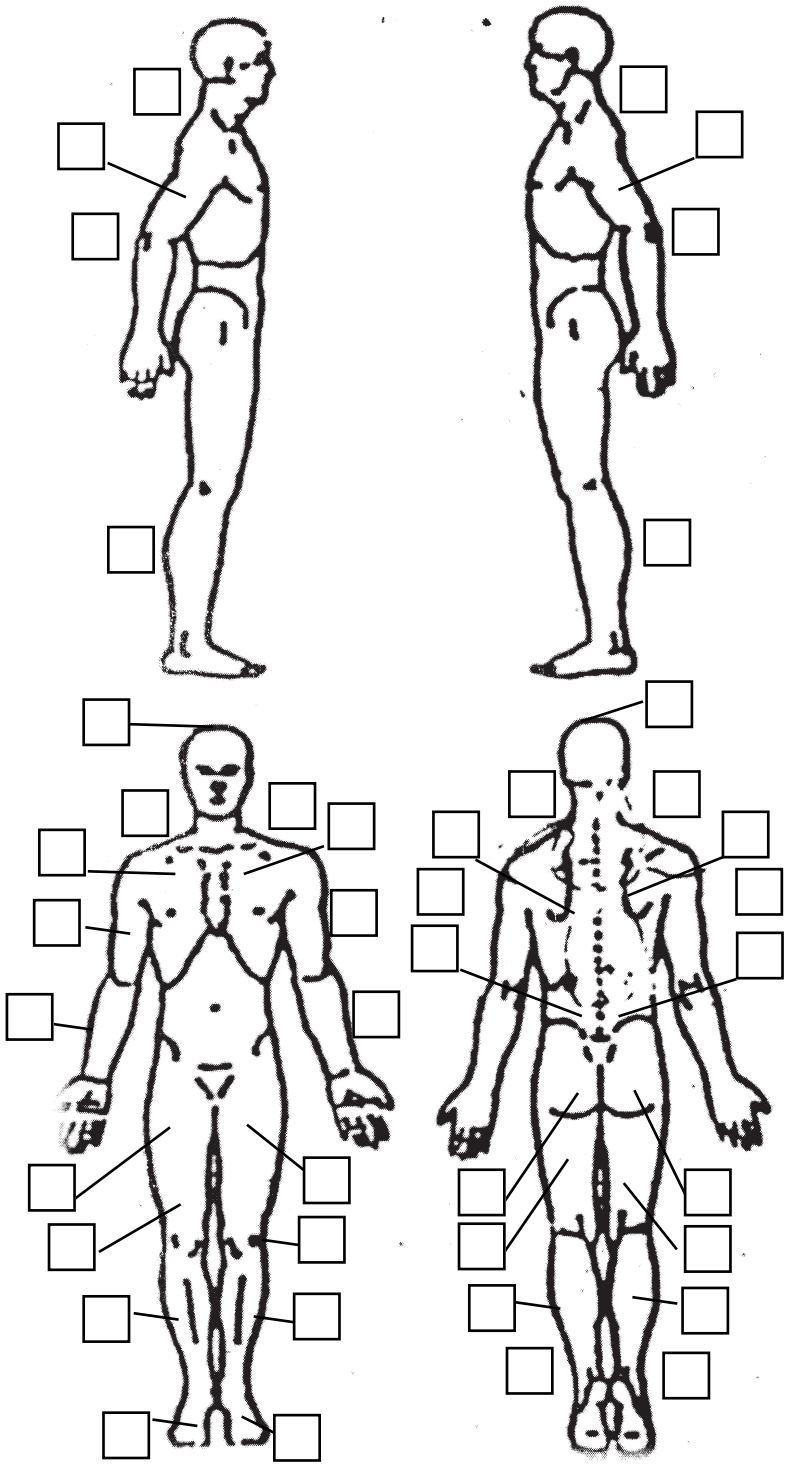
ACADEMY massage therapy

561 Academy Road
[204]489.5050
www.academymassage.ca

Please indicate the type and location of your symptoms



PLEASE PRINT

First Name _____

Last Name _____

Birthday: YEAR _____ MONTH _____ DAY _____

Gender _____

Address _____

City _____

Province _____

Postal Code _____

Home Phone _____

Cell Phone _____

Work Phone _____

Email _____

Physician _____

Place of employment/occupation

_____

Emergency Contact _____

Do you have insurance coverage? ☐ YES ☐ NO

If answered yes please indicate which company and your policy numbers

Primary Plan (name and number) _____

Secondary Plan (name and number) _____

Ask reception if you are eligible for direct billing

Client Name: _____ Date: _____

Please check if you are currently experiencing or have experienced any of the following conditions in the past.

- ☐ Contagious disease
- ☐ Arthritis/osteoporosis
- ☐ Heart disease
- ☐ High/low blood pressure
- ☐ Painful muscle tension
- ☐ Headache/migraine
- ☐ Muscle cramps
- ☐ Aching joints
- ☐ Dislocations/subluxation
- ☐ Shortness of breath
- ☐ Chest pain
- ☐ Dizziness/fainting
- ☐ Bruise easily
- ☐ Varicose veins
- ☐ Eczema
- ☐ Psoriasis
- ☐ Digestions trouble
- ☐ Stomach problems
- ☐ Anxiety
- ☐ Depression
- ☐ Kidney disease
- ☐ Epilepsy
- ☐ Skin infection
- ☐ Communicable skin infection
- ☐ Frequently Tired
- ☐ Hemophilia
- ☐ Herniation

- ❑ Do you smoke? ☐ YES ☐ NO
- ❑ Do you exercise? _____ times/week
- ❑ Do you drink? _____times/week

WOMEN

- ☐ Frequent menstrual cramping
- ☐ Pelvic inflammation/infection

Are you pregnant? YES NO

If yes how many months/weeks? _____

MEN

- ☐ Prostrate/urinary infection

Please list any allergies you may have.

Please list any medications you currently use.

I understand that the personal information provided by me will be kept confidential and secure and only used by the therapist and administrative personnel of Academy Massage Therapy to further any treatment I receive and if applicable to provide information to my insurance provider to facilitate the release of funds to cover my payments to Academy Massage Therapy.

I understand why the personal medical information which I am providing is needed by Academy Massage Therapy and I authorize them to keep this information on file to be used as necessary. I give permission for this information to be shredded after it have been saved in a medical program.

I have the opportunity to ask questions and understand and agree that Academy Massage Therapy and its therapists are not responsible for any unforeseen medical complications. I understand that sometimes pain and discomfort my be felt after any manual therapy is performed. I agree to exercise my judgement during treatment and will inform the practitioner of any changes or concerns I may have. I agree to wave my right to hold Academy Massage Therapy and practitioners / massage therapist to any claim of liability.

24-hour notice of cancellation is required or a fee will be charged. Client is responsible for any non-payments of direct billing services. No discounts apply on direct billing service. I agree to be responsible for payment not covered by my insurance provider. I the undersigned understand that my private insurance and all details and requirements of my policy are my responsibility and that it is my obligation to be aware of those details. If my insurance fails to make payment for services rendered I agree to make any outstanding balance promptly.

Academy Massage Therapy is not responsible for loss or damage to personal items.

Patient Signature (if under 18 signature of parent or guardian) _____