PINE MASSAGE THERAPY

SUITE 406 – 1755 WEST BROADWAY VANCOUVER, BC CANADA V6J 4S5 PHONE: **604.739.7988** FAX: **604.714.0053**

PLEASE COMPLETE ***BOTH SIDES*** OF THIS QUESTIONNAIRE. YOUR ANSWERS WILL HELP US DETERMINE THE CAUSE OF YOUR PROBLEM AND THE MODALITY THAT WILL BEST SERVE YOU. THANK-YOU.

NAME _____

ADDRESS _____ CITY, PROVINCE _____

POSTAL CODE _____ PHONE (1st) _____ (2nd) _____

AGE _____ DATE OF BIRTH (month/day/year) _____

PERSONAL HEALTHCARE NUMBER _____

OCCUPATION _____

HOBBIES AND INTERESTS _____

EMAIL ADDRESS _____

Check here if you wish to receive email reminders before your next appointment □

(Note: Our scheduling system will send you a welcome email with a user name and password. This will allow you to access your account, which includes appointment times, receipts and searching for open appointments online.)

MEDICAL DOCTOR _____ PHONE _____

ADDRESS _____

HOW DID YOU HEAR ABOUT OUR OFFICE? FAMILY/FRIEND □ DOCTOR □ INTERNET □ PERSONAL TRAINER □

OTHER: _____

MEDICAL BACKGROUND

DO YOU WEAR/HAVE: PINS/PLATES □ ORTHOTICS □ LOCATION: _____

DO YOU EXERCISE REGULARLY? IF YES, WHAT AND HOW MUCH? _____

_____

DO YOU SMOKE? IF YES, HOW MUCH? _____

DO YOU DRINK? IF YES, HOW MUCH? _____

DO YOU HAVE ANY KNOWN ALLERGIES (Medications, foods, oils and lotions, etc.)? _____

_____

HAVE YOU EVER HAD ANY MAJOR SURGERY OR ILLNESS? IF YES, PLEASE DESCRIBE. _____

_____

_____

ARE YOU PRESENTLY TAKING ANY MEDICATIONS, VITAMINS, MINERAL OR OTHER SUPPLEMENTS? YES___ NO___

IF YES, WHAT TYPE AND FOR WHAT CONDITION._____

_____

PLEASE INCLUDE ANY OTHER HEALTH CONDITIONS NOT ADDRESSED ABOVE. _____

_____

REASON FOR CONSULTING THIS OFFICE

IS YOUR PRESENT COMPLAINT: WCB □ ICBC □ OTHER _____

BRIEFLY DESCRIBE YOUR COMPLAINT. _____

_____

HOW LONG HAVE YOU HAD THIS PROBLEM? _____

HAVE YOU HAD THIS, OR SIMILAR PROBLEM IN THE PAST? _____

IS THIS CONDITION GETTING: WORSE □ UNCHANGED □ BETTER □

IS THIS CONDITION INTERFERING WITH YOUR: WORK □ SLEEP □ DAILY ROUTINE □ OTHER _____

WHAT MAKES THE CONDITION WORSE?

Standing □ Sitting □ Running □ Lifting □ Twisting □ Other _____

WHAT MAKES THE CONDITION BETTER?

Rest □ Ice □ Heat □ Stretching □ Medication □ Other _____

HAVE YOU HAD ANY OTHER HEALTHCARE PRACTITIONER(S) TREAT THIS CONDITION? IF SO, WHO? _____

_____

ANY ADDITIONAL COMPLAINTS? _____

INFORMED CONSENT TO MASSAGE THERAPY

THIS CLINIC MAKES EVERY EFFORT TO ENSURE THAT YOUR TREATMENT IS SAFE AND EFFECTIVE. IN PARTICULAR, YOU SHOULD NOTE:

a) ***Potentially painful treatments***. Although some treatments maybe painful, every effort is made to minimize the discomfort. Treatment can cease or be modified at anytime at the patient's request.

b) ***Removal of clothing***. Only in the areas to be treated, is the removal of certain clothing preferred for effective treatment. It is the right of the patient to decline the removal of certain or any clothing. If the patient wishes, they have the option of bringing and wearing shorts and sports bra (for women) during their treatment.

c) ***Files***. This clinic will be keeping all recorded information as part of your patient file. The collection, use and disclosure of personal information, as defined in the ***Personal Information and Privacy Act***, will only be used for treatment and or any related administrative purposes. If your file is ever needed in a legal matter, your file will not be released without your prior consent.

d) ***Cancellations, lateness, and "No Shows".*** "No Shows" and cancellations made less than 24hrs. prior to appointment time will be billed the **full amount**. Please note that we cannot bill insurance agencies for missed appointments. For the consideration of staff and other patients, please do not be late for your appointment. In the event you are late, we may be unable to accommodate your complete treatment time.

I acknowledge I have discussed, or have had the opportunity to discuss, with my Registered Massage Therapist the nature and purpose of massage therapy. I consent to the massage therapy treatment offered or recommended to me, by my Registered Massage Therapist. I intend this consent to apply to all my present and future massage therapy care.

Dated this _____ day of _____, 20 _____

PATIENT NAME (please print): _____ WITNESS NAME (please print): _____

PATIENT SIGNATURE: _____ WITNESS SIGNATURE: _____

OFFICE USE

RANGE OF MOTION: **MEASURED □ ESTIMATED □**

CERVICAL	***ACTIVE***	***PASSIVE***	***RESISTED***
FLEXION	__/60	__/60	_____
EXTENSION	__/75	__/75	_____
L-LATERAL FLEXION	__/45	__/45	_____
R-LATERAL FLEXION	__/45	__/45	_____
L-ROTATION	__/80	__/80	_____
R-ROTATION	__/80	__/80	_____