Confidential Client History

Name:_____Date:_____
Address:_____
_____Postal Code:_____
Preferred Contact Phone #:_____Alt.Phone#:_____
Date of Birth(d/m/y):_____Email:_____
Occupation:_____
Family Physician:_____

Would you like to be "reminded" of future appointments?_____
If yes, would you prefer an **email** reminder or **telephone** call (please circle one)

Reason for today's visit:_____
_____
Has this issue been treated before?_____If yes, how?_____
_____
Are you currently receiving any other type of treatment?_____
_____
Any past injuries or conditions?_____
_____
Any stiffness or pain as a result of these past injuries?_____
_____

Medications**:**

Name:	Dosage:	Reason for taking:
_____	_____	_____
_____	_____	_____
_____	_____	_____

CHECK IF ANY:

___cancer	___diabetes	___epilepsy	___high blood pressure
___heart disease	___stroke	___paralysis	___other(please specify)

CHECK ANY THAT YOU EXPERIENCE ONCE OR TWICE PER WEEK:

____headache	____constipation
____faintness/dizziness	____diarrhea
____tightness of jaw	____constant soreness in muscles
____grinding of teeth	____pain in heart or chest
____weakness in body parts	____insomnia
____nervousness	____fatigue
____poor appetite	____heavy feeling in limbs
____indigestion	____cold hands/feet
____excessive urination	____lower back pain

____allergies:_____
Do you smoke? (#per day)_____ For Women: Are you pregnant?_____

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PLEASE LIST REGULAR ACTIVITIES:

Activity:	Times Per Week:
_____	_____
_____	_____
_____	_____

Treatment Consent and Cancellation Policy:

I hereby give permission to the massage therapist to administer treatment for the purpose of soft tissue rehabilitation, relief from muscular tension/spasm/pain, for increasing circulation and stress reduction.
I have stated all my known medical conditions and take it upon myself to keep the therapist updated on my physical health.
Further, I understand that payment is expected as services are rendered unless prior financial arrangements have been made.

Signature:_____

Cancellation policy is as follows: Must cancel 6 business hours in advance (after hours does not apply), send someone else in your place, or pay a late cancellation fee of $20.00 less than the treatment fee. If you arrive late you will receive the remainder of your booked massage time. You will be required to pay for the time booked. *Thank you for your co-operation and understanding.*

Signature:_____

Information for Direct Billing:

If Blue Cross or Green Shield is your ***primary*** insurance provider, please fill in the appropriate information to direct bill your massage. Please note that if for any reason direct billing cannot be completed, you are still responsible to pay for your treatment.

Blue Cross

Group #_____
ID # _____
Date of Birth: _____
Are you entitled to receive comparable benefits from any other insurance company, health benefits company or Alberta Blue Cross Plan? Yes No

Green Shield

ID#: _____ Name of Primary Cardholder: _____

I authorize Jessica Zabolotney to receive direct payment for the massage provided _____ (please sign)