WELCOME TO YOUR MASSAGE EXPERTS EXPERIENCE!

Please fill out this form with all requested information before your treatment begins.

******* Please turn off your *mobile devices* while enjoying our surroundings *******

FULL NAME _____

BIRTHDATE MONTH / DAY / YEAR _____ GENDER _____

EMAIL ADDRESS _____

ADDRESS _____

CITY/PROV/PC CITY _____ PROV. _____ POSTAL CODE _____

HOME/WORK/CELL PH# HOME _____ WORK _____ CELL _____

YOUR OCCUPATION _____ YOUR #HRS PER WEEK _____

EMERG CONTACT NAME _____ EMERG PHONE NUMBER _____

PRIMARY CARE PHYSICIAN _____

ADDRESS / PHONE # _____

EMAIL COMMUNICATION:

Can Massage Experts send you appointment confirmations, reminders, & receipt emails? □ Y □ N

Can Massage Experts add your email to our marketing database (approx. 1-2/month)? □ Y □ N

**** Your email is used by Massage Experts only, and will never be given to a third party. You can unsubscribe to emails at any time.*

INSURANCE BILLING:

Where eligible, can Massage Experts submit direct billing, electronic claims, on your behalf, and receive direct payment in return for our services? □ Y □ N

INSURANCE COMPANY _____ EMPLOYER _____

POLICY / GROUP# _____ ID# _____

**** Please give insurance card to Front Desk, prior to entering treatment. Should you have a doctor's note, please provide this as well.*

**** Should your coverage change, please advise Front Desk.*

AIR MILES® NUMBER _____ NAME ON CARD _____

(if applicable) **** Get 1 AIR MILES® Reward Mile for every $20 you spend.*

What prompted your Massage Experts visit today? *(check all that apply)*

□ Relaxation □ Personal Health □ Injury/Pain □ Stress

Other: _____

Are you affected by any of the following conditions? *(check all that apply)*

□ Allergies or Hypersensitivity Reactions
□ Arthritis / Bursitis
□ Asthma / Emphysema / Chronic Cough
□ Athlete's Foot
□ Cancer Where _____
□ Carpal Tunnel Syndrome
□ Crohn's / Colitis
□ Depression or □ Mental Illness
□ Diabetes
□ Edema
□ Epilepsy
□ Fever
□ Fibromyalgia
□ Flu / Cold Virus
□ Gastro-Intestinal / Digestive Ailments
□ Headaches / Migraines
□ Hearing or Vision Loss
□ Heart Attack / Disease / Failure
□ Hepatitis A, B, or C or Herpes
□ High Cholesterol
□ High or □ Low Blood Pressure
□ HIV / Aids
□ Infection(s) Where _____
□ Infectious Disease
□ Metal Plates / Screws / Implants
□ Neck/ Spine Injury
□ Numbness / Tingling
□ Osteoporosis
□ Pacemaker or Similar Device
□ Poor Circulation
□ Pregnancy # of Weeks _____
□ Recent Surgery
□ Shingles
□ Skin Irritations / Rashes / Warts
□ Smoker
□ Sports Injury
□ Stroke / Aneurysm
□ Varicose Veins / Phlebitis

Family History of: _____

Other (Please Explain): _____

Are you currently experiencing tissue, joint, muscle discomfort? In what area? *(check all that apply)*

□ Jaw □ Neck □ Shoulders □ S/Blades □ Arms □ Hands □ Back
□ Upper Back □ Middle Back □ Lower Back □ Hips □ Legs □ Knees □ Feet

Explain: _____

What is the primary concern or physical complaint which has inspired your visit today?

Please rate your current sense of overall general health and wellbeing:

□ Great □ Fair □ Average □ Below Average □ Poor

Are you receiving any ongoing medical care for conditions not listed above? □ Y □ N

Explain: _____

Expectant mothers: Are you experiencing any complications during this pregnancy? □ Y □ N

Explain: _____

Have you been in a major automobile accident or have an injury we should know about? □ Y □ N

Date and Explain: _____

Do you currently see any other healthcare practitioners? *(check all that apply)* □ Y □ N

□ Acupuncture □ Chiropractor □ Naturopath □ Osteopath □ Physiotherapy □ Other

Have you ever had a registered massage? □ Y □ N

Approximate Last Date: _____

Please list any recent or significant surgeries and their approximate dates:

1 _____ 2 _____

3 _____ 4 _____

Please list medications and what they are treating: *(prescribed, natural supplements, and other)*

1 _____ 2 _____

3 _____ 4 _____

Have you taken an anti-inflammatory or painkiller today? *(Tylenol, Aleve, Aspirin, Advil)* □ Y □ N

Please Share with Us How You Discovered Massage Experts (Circle All That Apply):

□ Facebook □ Twitter □ Kijiji □ Google Search □ Bing Search

□ Mail Flyer / Postcard □ Radio □ Local Gym □ Newspaper □ Physician

□ Chamber of Commerce □ Walk-By □ SNAP Magazine □ Television □ Friend

Referred by: _____

Please read and acknowledge by signing the below:

- ✓ You are expected to be punctual as your treatment time(s) have been specifically reserved for you, and will not be extended.
- ✓ Please advise your Massage Therapist on whether the pressure is sufficient or too strong. A massage is always customized to you.
- ✓ As your health status changes, you will advise us, so that we may update my file. Failure on your part to disclose any health information could possibly result in my injury and/or illness, and you hereby release Massage Experts from any claims resulting as such.
- ✓ You understand that all appointment times include a pre-health assessment or health consultation, as well as appropriate change time.
- ✓ You authorize Massage Experts to contact the above doctor or health-related specialist if required for treatment purposes.
- ✓ It is by your free-will that you are receiving this massage therapy today and in future visits.
- ✓ To the best of your knowledge the above information is true and is the most up-to-date information you can give the attending massage therapist.
- ✓ You understand that this information given is confidential, unless required by law, and will only be released with your written consent.
- ✓ Your information will not be used for any other purpose than to assist your massage therapist in providing you with a personalized and safe massage which will take into consideration your individual health requirements.
- ✓ The information provided to you by your massage therapist is for general purpose only, and is not intended for any medical diagnosis.
- ✓ You understand that your therapist can terminate treatment at any point due to inappropriate behaviour.
- ✓ **You understand that 24-hours' notice is required to cancel or reschedule all appointments, or full charges will apply.**

SIGNATURE: _____ **DATE:** MO/DA/YEAR _____

Dated:	**OFFICE USE ONLY: Description of Health Changes, If Any:**	**Client Initials:**
MO/DA/YEAR		
MO/DA/YEAR		
MO/DA/YEAR		