

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 _____

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

Other: _____

Are you currently experiencing joint / muscle discomfort? (check all that apply)

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

Explain: _____

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 ever been in a major automobile accident that 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:

1 _____ 2 _____
3 _____ 4 _____

Are you currently on any medication? (prescribed, natural supplements, other)

Y N

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

MO/DA/YEAR

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