Falconridge Physiotherapy

Name: _____ Phone: _____

Address: _____

City: _____ Province: _____ Postal Code: _____

Email: _____

Date of Birth: (M/D/Y) _____ Occupation: _____

Emergency Contact: _____ Relationship: _____

Emergency Contact Phone: _____

Physicians Name: _____ Contact Number: _____

Billing & Payment

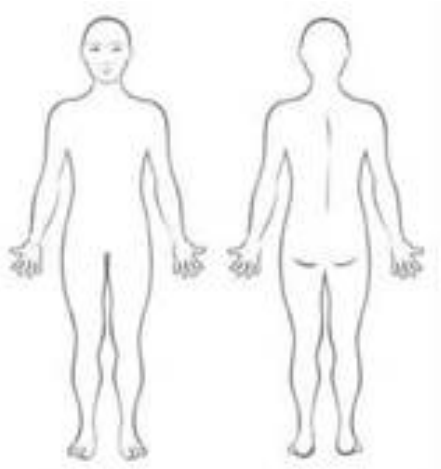
I authorize Falconridge Physiotherapy & Massage to submit claims on my behalf to my insurance company and I am responsible to pay any co-payment or any outstanding balance for my Massage Services at each time. In the event my insurance company denies the payment for any reason, I would be responsible to pay for my whole session.

Patient/ Parent/Guardian signature: _____ Date: _____

If you are under 18, Parent/Guardian must sign.

The following information will be used to help plan safe and effective massage sessions.
Please answer the questions to the best of your knowledge:

1. Have you ever had a professional massage before? ☐ yes ☐ no
2. Do you have any difficulty lying on your front, back, side? ☐ yes ☐ no
   If yes, please explain _____
3. Do you have any allergies to oils, lotions, or ointments? ☐ yes ☐ no
   If yes, please explain _____
4. Do you have sensitive skin? ☐ yes ☐ no
5. Do you sit for long hours at a workstation, computer, or driving? ☐ yes ☐ no
6. Do you perform any repetitive movement in your work, sports, or hobby? ☐ yes ☐ no
   If yes, please describe _____
7. Do you experience stress in your work, family, or other aspects of your life? ☐ yes ☐ no
   If yes, how do you think it has affected your health?
   ☐ muscle tension ☐ anxiety ☐ insomnia ☐ irritability ☐ other _____
8. Is there a particular area of the body where you are experiencing tension, stiffness, pain, or other discomfort? ☐ yes ☐ no
   If yes, please identify _____
9. Do you have any goals in mind for this massage session? yes☐ no ☐
10. Circle any specific areas you would like the massage therapist to concentrate on during



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MEDICAL HISTORY

To plan a massage session that is safe and effective, we need some general information about your medical history.

11. Are you currently under medical supervision? ☐ yes ☐ no
    If yes, please explain _____

12. Do you see a chiropractor? ☐ yes ☐ no
    If yes, how often? _____

13. What is your primary complaint (or body part injury or pain)? _____

14. Please provide a list of any surgeries, past injury, or past condition you've had: _____
    _____

15. Is your pain related to ☐Car accident (date of MVA) ☐Work related injury (date of injury) ☐Stress

16. Are you pregnant? ☐Yes ☐ No ▬Not sure. If Yes, how many weeks? _____
    If Yes _____, I understand and voluntarily consent to receive massage therapy while understanding all possible risk (if any)

17. Is there anything else about your health history that you think would be useful for your massage practitioner to know? _____
_____

Draping will be used during the session - only the area being worked on will be uncovered.

CONSENT

_____I understand that the massage I receive is provided for the basic purpose of relaxation and relief of muscular tension. If I experience any pain or discomfort during this session, I will immediately inform the therapist so that the pressure and/or strokes may be adjusted to the level of comfort.

_____I understand that massage therapists are not qualified to perform spinal or skeletal adjustments, diagnose, prescribe, or treat any physical or mental illness, and that nothing said during the session given should be construed as such.

_____I affirm that I have stated all my known medical conditions and answered all questions honestly. I agree to keep the therapist updated as to any changes in my medical profile and understand that there shall be no liability on the therapist's part should I fail to do so.

_____Sexual advances, request for sexual favours, and other verbal or physical conduct of a sexual nature will constitute as sexual harassment and will not be tolerated. Your session will be immediately terminated, and you will be responsible to pay in full for the session booked. You must then leave the premises and will be prohibited to return to the clinic in the future.

_____**Patients are responsible for providing 24 hrs notice for appointment cancellation. If you cancel without notice, 50% of the service will be charged to you directly.**

_____ _____
Client Signature Date

_____ _____
Therapist Signature Date