

Medical History

Name: _____

DOB: _____

1. Have you had massage therapy before?
2. Do you presently have an ICBC/WCB claim?
ICBC/WCB will be informed, in writing of your progress and attendance.
3. Please list any serious illness, injury, accident or surgery you have experienced.

4. Are you presently taking any medications (please specify)?

5. Are you currently seeing one or more of the following practioners?

Massage Therapist Physiotherapist Chiropractor Other(please specify) _____

Please check any of the following which you have experienced in the past or are currently experiencing:

| | Past | Present | | Past | Present |
|---------------------|------|---------|---------------------|------|---------|
| Muscular Tightness | | | Jaw Pain | | |
| Numbness & Tingling | | | High Blood Pressure | | |
| Painful Joints | | | Fainting, Dizziness | | |
| Arthritis | | | Chest Pain | | |
| Disc Problem | | | HIV Positive | | |
| Fractures | | | AIDS | | |
| Skin Conditions | | | Blurred Vision | | |
| Cancer | | | Fatigue | | |
| Contagious Disease | | | Ear Problems | | |
| Pregnancy | | | Insomnia | | |
| Anemia | | | Headaches | | |

This is to acknowledge by wish and consent to pay the required USER FEE per Massage Therapy Treatment. I understand that MSP, WCB & ICBC pay for a 30 minute visit. If I choose to have additional time/or addition treatment there will be additional cost to myself. In consideration of my acceptance as a patient of Massage Therapy, I whereby waive and release any and all claims for damages I may have against Physiomoves Physiotherapy Clinic and Tyler L. Dumont Physiotherapist Corp., for any and all claims of liability. In addition, if your claim is suspended or rejected or any reason you are responsible for the full cost of treatment.

I agree to pay the equivalent of my appointment fee for a missed appointment or cancelled appointment with less than 24 hours notice being given.

Signature: _____

Date: _____

Please provide us with your email address for email reminders.