aloe massage therapy

Name ______________________ Address ______________________

Birth date(M/D/Y) ______________________ ______________________

Phone (home) ______________________ ICBC Claim? Y or N

(Work) ______________________ Family doctor ______________________

(Cell) ______________________ Occupation ______________________

Email ______________________ How did you hear about us?______________________

Please check all of the following that apply (past or current)

- ☐ **Circulatory Conditions** (ex. High or low blood pressure, Other heart conditions, Varicose veins, Bruise easily, other)
- ☐ **Kidney Conditions** (ex. Kidney disease, Diabetes)
- ☐ **Pregnancy**
- ☐ **Cancer**
- ☐ **Neurological Conditions** (ex. Headaches or Migraines, Dizziness, Fainting, Nausea, Head injury, Spinal injury, Epilepsy, Other)
- ☐ **Respiratory Conditions** (ex. Asthma, Chronic sinusitis, Other)
- ☐ **Contagious Conditions** (ex. Hepatitis, HIV)
- ☐ **Digestive condition** (ex. IBS/Colitis)
- ☐ **Skin conditions**
- ☐ **Joint Conditions** (ex. Joint dislocation, Arthritis)
- ☐ **Bone Conditions** (ex. Fracture/ break, Osteoporosis, Rods/Pins/Plates)

Medications you presently take______________________

Known allergies ______________________

Major accidents, illnesses or surgeries ______________________

____

Activities, sports or hobbies ______________________

Current Condition

Please describe your current condition and symptoms

____

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____

____

How long have you had this condition? ______________________

____

____

How did it start? ______________________

____

____

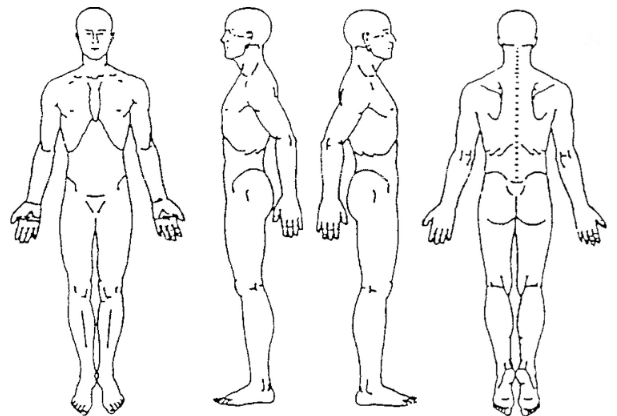
What aggravates it? ______________________

____

What relieves it? ______________________

____

Indicate the location of your symptoms.



Please note: Your appointment time has been reserved for you. In courtesy of your therapist & fellow patients, we ask that you provide us with 24 hours notice of cancellation, or a cancellation fee will be charged. Email reminders for appointments are a courtesy, if you don't receive one; it is still your responsibility to arrive on time for the appointment. Payment for all treatments, whether private or insured, is ultimately the responsibility of the patient.

I authorize the clinic and its associated RMTs to collect my personal medical information as documented above in order to contact me, and give permission for the clinic to leave messages regarding appointments at any of the contact numbers/email addresses I have provided. In addition, I authorize the clinic and its associated RMTs to communicate with my referring MD as deemed necessary for my beneficial treatment. I also understand that my personal and medical information is confidential and will only be disclosed to third parties with my permission.

Signature ______________________Date: ______________________

Electronic Billing of Third Party Insurance

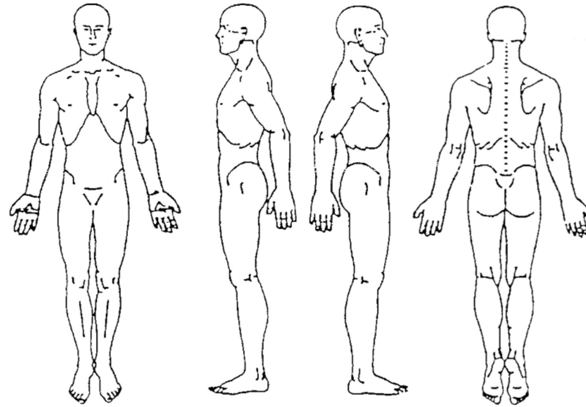
Insurance Provider ____

Plan/Policy #______________________________ **Certificate/Member ID**____

☐ **I have read the Electronic Transmission Authorization, Benefit Assignment, and Consent Form. Please initial** _______________

Print Name (clearly):____ **Signature**____

For Office Use only:



Name: ____