Last Name: _____ First Name: _____

Address: _____

City: _____ Province: _____ Postal Code: _____

Phone #: (home) _____ (work) _____ (cell)_____

Family Doctor: _____

Gender: ☐ Male ☐ Female Date of Birth: (month) _____ (day) _____ (year) _____

Alberta Health Care #: _____

Name of Guardian: (if under 18) _____

Emergency Contact Name: _____ Phone #: _____

Referred by: Dr. _____ Friend _____ Walk In Other _____

I hereby consent to this assessment and subsequent massage treatments.

_____ _____

Patient (*or Guardian*) Signature Date

OFFICE POLICIES

Electronic Messaging

In order to best serve our clients it is necessary to obtain your expressed consent permitting us to electronically communicate with you. This includes, but is not limited to, appointment reminders, relevant news, consultation letters and/or notes with consulting doctors.

☐ I agree to receive all forms of electronic messaging from Northern Hills Sport Physiotherapy inclusive of all staff members. I understand that I can withdraw my consent at any time. To do so, I can contact Northern Hills Sport Physiotherapy for more details.

Email address: _____

Direct Billing to Third Parties

Our office is happy to offer our clients direct billing for services to WCB, motor vehicle companies and most extended health care plans. Should your claim not be covered for ANY reason, including errors and omissions by Northern Hills Sport Physiotherapy, you are ultimately responsible for any charges incurred.

Cancellations and Missed Appointments

At Northern Hills Sport Physiotherapy we value your time and show this by doing our best to stay on schedule. In return, we expect our clients to do their best to attend scheduled appointments.

- 24 hours' notice is required for rescheduling or cancelling appointments.
- All missed or cancelled appointments with less than 24 hours' notice will be charged $50% of the service missed.
- Chronically missed appointments will result in a charge of 100% of the service missed, and future appointments will require prepayment at the time of booking.
- Fees for missed appointments or late cancellations will be charged to you (not to any third party).

I, _____, acknowledge that I have read and understand the
(please print)
above policies.

_____ _____

Patient (or Guardian) signature Date

NORTHERN HILLS SPORT PHYSIOTHERAPY

MASSAGE HEALTH HISTORY

Patient Name _____

What is the primary reason for your visit? _____

Please indicate below conditions that you are experiencing, or have experienced:

Respiratory

☐ chronic cough
☐ shortness of breath
☐ bronchitis
☐ asthma
☐ emphysema

Cardiovascular

☐ high blood pressure
☐ low blood pressure
☐ CCHF
☐ heart attack
☐ phlebitis
☐ stroke/CVA
☐ pacemaker or similar device
☐ heart disease

Skin

☐ skin conditions

Other Conditions

☐ loss of sensation
☐ diabetes (onset: _____)
☐ allergies (ie anaphlaxis or skin irritation)
☐ epilepsy
☐ cancer
☐ arthritis

Head/Neck

☐ vision problems
☐ vision loss
☐ ear problems
☐ hearing loss

Infections

☐ hepatitis
☐ skin conditions
☐ TB
☐ HIV

Women

☐ pregnant (due: _____)

Soft tissue/joint discomfort and its nature

☐ neck
☐ shoulders
☐ upper back
☐ mid back
☐ low back
☐ arms
☐ legs
☐ knees
☐ other:

What is your general health status?

_____

What is your occupation?

_____

Current medication(s): _____ Condition(s) it treats: _____

Surgery: _____ Date: _____ Nature: _____

Injury: _____ Date: _____ Nature: _____

Other Medical Conditions (eg. Digestive conditions, gynaecological conditions, hemophilia, etc.):

Of Special Note: (presence of internal pins, wires, artificial joints, special equipment):

An accurate health history is important to ensure that it is safe for you to receive a massage treatment. If your health status changes in the future, please let your massage therapist know.

Patient (*or Guardian*) Signature: _____ Date: _____

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