Massage Therapy Confidential Health History

Name _____ **Employer** _____

Address _____ **Phone** (home) _____

City _____ (cell) _____

Postal Code _____ **Birthday** _____ (work) _____

Care Card Number _____

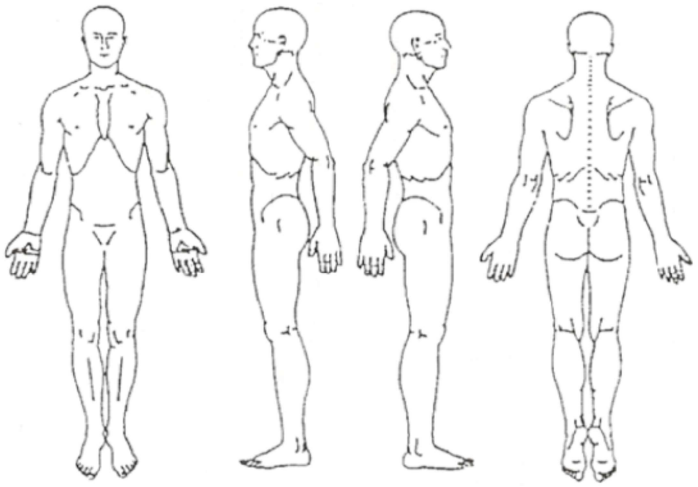
Email _____ How did you hear of our clinic? _____

Family Doctor _____ May we forward a clinical progress note to them? Yes No

Extended Heath Care Provider _____Client/Plan Number _____

Is this an ICBC/WCB claim? If Yes, Date of accident _____ICBC/WCB claim # _____

Why are you seeking Massage Therapy today? _____



Location of Complaint: Please use the drawing

How intense is the pain? (make a dash along the line)

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no pain — worst possible pain

Is it getting: ○ better ○ worse ○ constant ○ comes and goes

Is this interfering with your: ○ work ○ sleep ○ daily routine ○ recreation ○ other_____

How and when did this complaint begin? _____

Does anything aggravate it? _____

Does anything make it better? _____

Previous treatments, medications, and surgery you've sought for this complaint? _____

Current medical conditions: _____

Medications, and reasons for taking: _____

Previous medical conditions: _____

Previous injuries, traumas or broken bones: _____

Previous Surgeries: _____

Please list any blood-borne disease (HIV Hepatitis B etc): _____

Do you have any known allergies? _____

Welcome to Energy Health Clinic!!

101-2349 Millstream Rd., Victoria, BC, V9B 3R5, Phone: 250-391-8811, Fax: 250-391-8818

Welcome to our clinic! We are delighted to have you as a new patient and we look forward to providing you with the highest quality of care. Please note that some of our patients are sensitive to perfumes and colognes.

Current Fees

You have the option of paying cash, cheque, Interac, Visa, Mastercard or Amex. GST is included in all prices.

Length	Regular Fees	MSP Fees
30 min	$65.00	$40.85
45 min	$85.00	$60.85
60 min	$105.00	$80.85
90 min	$170.00	$145.85

Clinical Time includes: Administration, Assessment, Evaluation, Treatment, and Patient Education
Subsidized rates are available with MSP coverage.
There is no user fee for approved WSBC claims.
Gift Certificates are available.

Extended Health Coverage

Most extended health care plans cover massage therapy. Please check with your plan, as sometimes a medical doctor's referral is needed for you to be reimbursed. Sometimes we are able to **directly bill your health plan**. Please ask the receptionist for more details.

I permit to communication with Energy Health Clinic via email for appointment reminders.

Policies and Consent to Treatment

Your Registered Massage Therapist will recommend a treatment program for your recovery.
If you have preferences for certain times, we suggest you schedule them in advance.

Your appointment time is reserved just for you. A late cancellation or missed visit leaves a hole in the therapists' day that could have been filled by another patient. As such, we require 12 hours notice for any cancellations or changes to your appointment. Patients who provide less than 12 hours notice, or miss their appointment, will be charged a full cancellation fee.

Massage Therapy uses various techniques to manipulate the soft tissues and to encourage the healing process. Occasionally after treatment the affected tissues may feel sore. This is part of the healing process and can be alleviated by using cold compression's or soaking in an Epson Salt bath. Active communication with the therapist regarding the depth of treatment will facilitate the recovery process and minimize discomfort.
I authorize the clinic and its associated health professionals to collect my personal and medical information as documented above. In addition, I authorize the clinic and its associated health professionals to communicate with my family doctor and/or referring doctor 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. I acknowledge I have discussed, or have had the opportunity to discuss, with my Massage Therapist the nature and purpose of Massage Therapy in general and in my treatment plan, and give my consent to receive treatment.

Patient Signature: _____ **Date:** _____