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

_____

_____

_____

_____

How long have you had this condition? _____

_____

_____

How did it start? _____

_____

_____

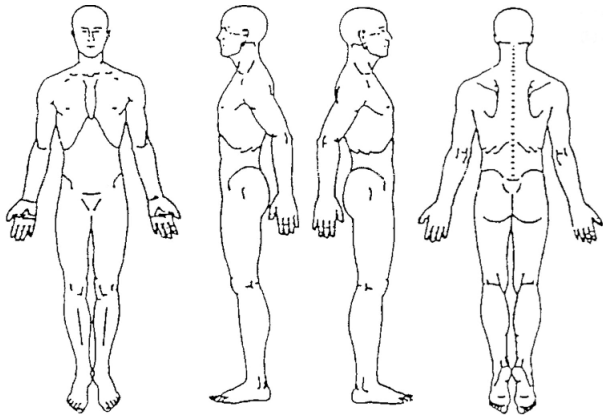
What aggravates it? _____

_____

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

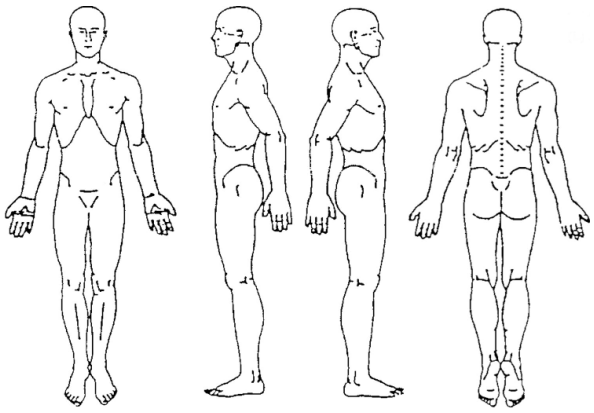
Insurance Provider _____

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: _____