



Confidential Patient Admittance Form

Name: _____ Age: _____ Martial Status: S M W D

Address: _____ City: _____ Postal Code: _____

Birthdate: _____ Care Card Number: _____

Home Phone: _____ Work Phone: _____ Cell: _____

Occupation: _____ Email Address: _____

Emergency Contact: _____ Phone: _____

Family Physician: _____ Phone: _____

WBC ICBC Claim #: _____ Date of Injury: _____

Adjustor's Name: _____ Phone: _____

How did you hear about this clinic? _____

Reason/Condition for coming: _____

Does the condition/pain affect your daily activities? If yes how? _____

How would you like to benefit from Massage Therapy treatment?

Rehabilitation/correction Injury prevention/health Pain management Stress reduction

How long has the above reason/condition existed? _____

Has this condition occurred before? Yes No Was it resolved? Yes No

Type of pain: sharp/excruciating burning/tingling aching/dull other

What aggravates it? _____

What relieves it? _____

Is it worse in the: morning midday evening night constant

Are you presently taking any medications? Yes No

Pain killers Muscle relaxants Anti-inflammatories Depression

Other Please list: _____

Do you have any allergies? Yes No Describe: _____

Have you had OR are you currently receiving treatment from any of the following?

Massage Therapy Chiropractor Physiotherapy Acupuncture Naturopath

Other Please list: _____

Please list any previous accidents, injuries, illnesses, or surgery:

Describe: _____

Continued over.....

Please **CIRCLE** the extent to which you are currently satisfied with the following:

(1 = poor, 5 = excellent)

Diet	1	2	3	4	5	Physical health and fitness	1	2	3	4	5
Energy level	1	2	3	4	5	Mental & emotional happiness	1	2	3	4	5
Ability to relax	1	2	3	4	5	Quality of sleep	1	2	3	4	5

Please **CIRCLE** your use of the following:

Water	none	light	mod.	Heavy	Tobacco	none	light	mod.	Heavy
Coffee	none	light	mod.	Heavy	Sugar	none	light	mod.	Heavy
Alcohol	none	light	mod.	Heavy	Salt	none	light	mod.	Heavy

Please **CIRCLE** the amount of stress you are subject to: none slight mod. Severe

List any regular Exercise, Sports, Hobbies, or Activities: _____

Please **CHECK (X)** the appropriate box if you have, or have had, any of the following conditions. Please **UNDERLINE** in the case of past family history.

AIDS/HIV	past <input type="checkbox"/> present <input type="checkbox"/>	Head or neck trauma	past <input type="checkbox"/> present <input type="checkbox"/>
Arthritis	past <input type="checkbox"/> present <input type="checkbox"/>	Depression	past <input type="checkbox"/> present <input type="checkbox"/>
Arteriosclerosis	past <input type="checkbox"/> present <input type="checkbox"/>	Dizziness	past <input type="checkbox"/> present <input type="checkbox"/>
Anemia	past <input type="checkbox"/> present <input type="checkbox"/>	Fainting	past <input type="checkbox"/> present <input type="checkbox"/>
Cancer	past <input type="checkbox"/> present <input type="checkbox"/>	Nausea	past <input type="checkbox"/> present <input type="checkbox"/>
Circulatory disorder	past <input type="checkbox"/> present <input type="checkbox"/>	Headaches	past <input type="checkbox"/> present <input type="checkbox"/>
Chest pains	past <input type="checkbox"/> present <input type="checkbox"/>	Visual problems	past <input type="checkbox"/> present <input type="checkbox"/>
Contagious disease	past <input type="checkbox"/> present <input type="checkbox"/>	Ear problems	past <input type="checkbox"/> present <input type="checkbox"/>
Diabetes	past <input type="checkbox"/> present <input type="checkbox"/>	Jaw pain	past <input type="checkbox"/> present <input type="checkbox"/>
Digestive disorder	past <input type="checkbox"/> present <input type="checkbox"/>	Neck pain	past <input type="checkbox"/> present <input type="checkbox"/>
Epilepsy	past <input type="checkbox"/> present <input type="checkbox"/>	Upper back/shoulder pain	past <input type="checkbox"/> present <input type="checkbox"/>
Hemophilia	past <input type="checkbox"/> present <input type="checkbox"/>	Mid back pain	past <input type="checkbox"/> present <input type="checkbox"/>
Heart condition	past <input type="checkbox"/> present <input type="checkbox"/>	Low back pain	past <input type="checkbox"/> present <input type="checkbox"/>
Hernia	past <input type="checkbox"/> present <input type="checkbox"/>	Spinal disc injury/disease	past <input type="checkbox"/> present <input type="checkbox"/>
High/low blood pressure	past <input type="checkbox"/> present <input type="checkbox"/>	Arm/wrist/hand pain	past <input type="checkbox"/> present <input type="checkbox"/>
Organ dysfunction	past <input type="checkbox"/> present <input type="checkbox"/>	Leg/ankle/foot pain	past <input type="checkbox"/> present <input type="checkbox"/>
Osteoporosis	past <input type="checkbox"/> present <input type="checkbox"/>	Fracture	past <input type="checkbox"/> present <input type="checkbox"/>
Pregnancy	past <input type="checkbox"/> present <input type="checkbox"/>	Dislocation	past <input type="checkbox"/> present <input type="checkbox"/>
Respiratory condition	past <input type="checkbox"/> present <input type="checkbox"/>	Sprain/strain	past <input type="checkbox"/> present <input type="checkbox"/>
Ulcers	past <input type="checkbox"/> present <input type="checkbox"/>	Unexplained/sudden weakness	past <input type="checkbox"/> present <input type="checkbox"/>
Skin condition	past <input type="checkbox"/> present <input type="checkbox"/>	Numbness/tingling	past <input type="checkbox"/> present <input type="checkbox"/>
Stroke	past <input type="checkbox"/> present <input type="checkbox"/>	Neurological condition	past <input type="checkbox"/> present <input type="checkbox"/>
Urinary disorder	past <input type="checkbox"/> present <input type="checkbox"/>	Loss of sleep	past <input type="checkbox"/> present <input type="checkbox"/>
Varicose veins	past <input type="checkbox"/> present <input type="checkbox"/>	Other _____	

MASSAGE THERAPY FEE SCHEDULE

<u>Initial visit</u>	60 min	\$ 90 (includes 12% HST)
<u>Subsequent visit</u>	30 min	\$ 56 (includes 12% HST)
	60 min	\$ 90 (includes 12% HST)

Please note that each visit includes the following steps: Administration, Assessment, Evaluation, Treatment, and Patient education (exercise, homecare, etc).

- **MSP:** Please notify reception to confirm coverage.
- **WCB:** Please notify reception to confirm claim acceptance and coverage.
- **ICBC:** ICBC rates may vary among therapists, please confirm fees with reception.
- **RCMP/DVA:** Private group plans cover massage therapy for RCMP officers and Veterans. Please confirm coverage with reception.

MD referral required for WCB, ICBC, RCMP, DVA and some extended health plans.
Please check your coverage with your extended health insurance provider.

Please note that a \$10 administration fee applies to the handling of insurance claims and is included in the fee schedule above.

Full payment of fees is expected on the date of service or by specific arrangement made by the front desk. Please note that fees are subject to change without notice.

Fee Policy & Consent to Treatment: Please read the following and sign below.

In consideration of your fellow patients and your therapist please **allow a minimum of 24 hours notice to change or cancel your appointment.** This allows us to reschedule that time period. **Missed appointments and/or short notice cancellations will be charged \$ 20.00 per 20 minute timeslot.** Please inform us if you are unable to make your appointment.

I understand and agree to the Fee Policy within this office. I agree to pay for any late cancellations or missed appointments, subject to my Therapist's discretion. If at any time I.C.B.C., W.C.B., M.S.P. or other third party refuses coverage I understand that it is my responsibility to pay the outstanding balance owed.

I hereby consent to receive treatment by John Reimer, R.M.T. and associates. I understand that this consent is fully voluntary and may be revoked by me at any time. I understand the fee structure and accept responsibility for prompt payment.

Patient's Signature: _____ **Date:** _____