AVANI
WELLNESS & MASSAGE

PATIENT ENTRANCE FORM

Name: _____ Date: _____

Address: _____
(Street) (City) (Province) (Postal Code)

Home Phone: _____ Cell Phone: _____

Date of Birth: _____ Age: _____ M / F Email: _____
(M/D/Y)

Occupation: _____ Employer: _____

Emergency Contact: _____ Phone: _____

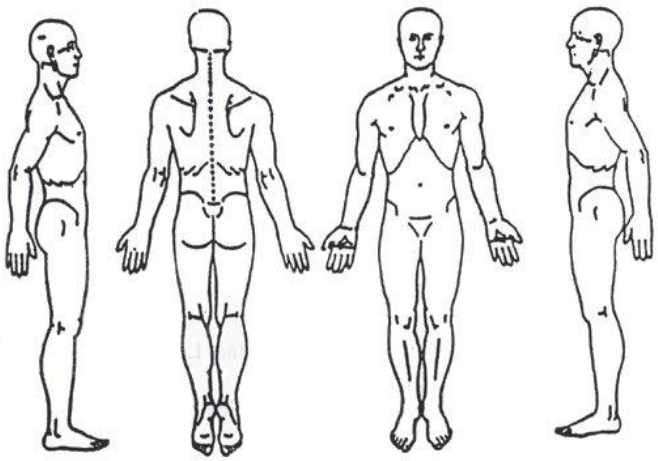
Medical Doctor: _____ Phone: _____

How did you hear about our clinic? Referral: _____ Website □ Sign □ Other _____

Have you ever seen a massage therapist before? Y N If yes, last visit date? _____

Are you seeking massage for relaxation □ or therapeutic benefits □

Describe your Complaint/Problem/Injury
Mark areas of pain/discomfort



_____

_____

When did this problem begin? _____

Have you had this in the past?
When? _____

Is it getting:
Worse □ Same □ Better □

Pains are:
Sharp □ Dull □ Achy □ Stabbing □

Is this interfering with your: Work □ Sleep □
Exercise □ Daily Activities □
Other: _____

Which activities aggravate your condition?
Bending □ Lifting □ Sitting □ Standing □
Coughing □ Sneezing □ Driving □ Exercise □
Other: _____

Which activities relieve your condition?
Rest □ Moving About □ Cold Pack □ Heat □
Other: _____

Other professionals consulted for this condition?

_____

Medical Tests, X-rays, MRI or CT scans for this condition?

_____

Other health problems/previous injuries/hospitalization

_____

_____

_____

_____

Do you have any internal pins/wires/artificial joints?

_____

_____

_____

Pain Scale: On a scale of **0** (no pain) to **10** (worst pain ever), how do you rate your pain level:

Right now: 0 1 2 3 4 5 6 7 8 9 10 **At its Worst:** 0 1 2 3 4 5 6 7 8 9 10 **At its Best:** 0 1 2 3 4 5 6 7 8 9 10

Please check all that apply.

HEAD / NECK
- Headache □
- Migraine □
- Visual disturbances □
- Contact lenses / Glasses □
- Earaches □
- Hearing problems □
- Jaw pain □
- Whiplash □
- Concussion □

CARDIOVASCULAR
- High / Low pressure □
- Chronic heart failure □
- Poor circulation □
- Heart disease □
- Phlebitis □
- Stroke □
- Heart attack □
- Pacemaker □
- Arteriosclerosis □
- Irregular heart beat □

RESPIRATORY
- Asthma □
- Chronic cough □
- Shortness of breath □
- Bronchitis □

MENTAL ILLNESS
- Anxiety □
- Depression □
- Other (please explain) □

_____

DIGESTIVE / URINARY
- Difficult digestion □
- Constipation □
- Liver / Gallbladder □
- Kidney / Urinary □
- Diabetes (type) _____
- Hypoglycemia □
- Crohn's disease □
- Irritable bowel □
- Ulcers □

SKIN
- Bruise easily □
- Eczema □
- Psoriasis □
- Sensitivity □
- Skin condition (please explain) □

_____

- Varicose veins □
- Loss of sensation □
- Athlete's foot □
- Cold sores □
- Plantar warts □

INFECTIOUS
- Tuberculosis □
- AIDS / HIV □
- Hepatitis □
- Infectious skin □

MUSCLE / JOINTS
- Neck □
- Lower back □
- Mid back □
- Upper back □
- Shoulder □
- Hip □
- Knee □
- Ankle □
- Other: _____

FEMALE
- Menstrual problems □
- Pregnancy □
- Due date: _____
- Menopausal issues □
- Gynecological problems □

OTHER
- Hemophiliac □
- Epilepsy □
- Cancer (please explain) □

_____

- Arthritis □
- Fibromyalgia □
- Osteoporosis □
- Chronic fatigue □
- Scoliosis □
- Carpal tunnel syndrome □
- Dizziness / Fainting □
- Hernia □

Are you currently taking any medications? Yes □ No □

If Yes, what type(s)?
Painkiller □ Anti-inflammatory □ Muscle relaxant □ Blood thinners □ Sleep □

Allergies: _____

Is there anything else your massage therapist needs to know? _____

Informed Consent for Massage Therapy Treatment

I understand that the massage therapist is providing massage therapy services within their scope of practice as defined by the Massage Therapist Association of Manitoba.

I hereby consent for my therapist to treat me with massage therapy for the above noted purposes including such assessments, examinations and techniques, which may be recommended, by my therapist.

I acknowledge that the therapist is not a physician and does not diagnose illness or disease or any other physical or mental disorder. I clearly understand that massage therapy is not a substitute for a medical examination. It is recommended that I attend my personal physician for any ailments that I may be experiencing. I acknowledge that no assurance or guarantee has been provided to me as to the results of the treatment. I acknowledge that with any treatment there can be risks and those risks have been explained to me and I assume those risks.

I acknowledge and understand that the therapist must be fully aware of my existing medical conditions. I have completed my medical history form as provided by my therapist and disclosed to the therapist all of those medical conditions affecting me. It is my responsibility to keep the massage therapist updated on my medical history. The information I have provided is true and complete to the best of my knowledge.

I authorize my therapist to release or obtain information pertaining to my condition(s) and/or treatment to/from my other caregivers or third party payers.

I have read the above noted consent and I have had the opportunity to question the contents and my therapy. By signing this form, I confirm my consent to treatment and intend this consent to cover the treatment discussed with me and such additional treatment as proposed by my therapist from time to time, to deal with my physical condition and for which I have sought treatment. I understand that at any time I may withdraw my consent and treatment will be stopped.

Patient Name: _____ Signature of Patient/Guardian: _____

Witness: _____ Date Signed: _____

Consent for Communication

I consent to the clinic to communicate electronically with me for the purpose of scheduling appointments and appointment confirmations. Yes □ □ No □

I consent to the clinic to communicate electronically with me for the purpose of clinic updates and newsletters. □ Yes □ □ No □

Payment

Payment is due at the time of service and we will provide you with a receipt you can submit to your insurance company for possible reimbursement.

Cancellation Policy

To avoid charges, please provide a minimum of 24 hours notice for cancellation. A 50 % cancellation fee will be charged if you cancel your appointment with less than 24 hours notice or if you do not show for your scheduled appointment time.

If your appointment is booked on the same day, please be aware that the cancellation policy will be in effect once your appointment is set. This is done in fairness both to clients who would otherwise have wanted the appointment as well as the therapist, who is not paid if they do not perform the session.

We take pride in the fact that our clients never wait and are never rushed. As a courtesy to everyone, thank you for being prompt. Late arrivals can only be extended to the time remaining in their scheduled session.

Direct Billing Information for Blue Cross Only

Certificate # _____ Client # _____

Relationship: Plan member □ Spouse/Common-Law Spouse □ Dependent □

Your insurance benefit is a contract between you & your insurance company. It is the responsibility of the patient to keep track of the number of visits related to insurance coverage maximums.

Please provide a credit card number below only for direct billing purposes. The card will only be charged if we are denied payment from the insurance company.

Visa/MC Card # _____ Exp. Date: _____ VIN # _____