BURNABY HEIGHTS Integrative HEALTHCARE

Clear Form

Help

Confidential Patient History Form for Registered Massage Therapy

Name _____ **Occupation** _____

Date of Birth _____ **Phone (H)** _____

(month / day / year) **(W)** _____

(C) _____

Mailing Address

_____

_____

_____

Postal Code_____

Preferred location of contact:

_____

E-mail _____

Care Card _____ **Referring Doctor** _____

How did you hear about Burnaby Heights Integrative HealthCare?

_____

Why are you seeking Massage Therapy today?

_____

Are you currently involved in an active ICBC or WCB claim? Yes No

Please answer the following questions about your current condition and symptoms:

Describe your current condition: _____

Is this new for you? _____ If not, how often have you experienced this? _____

How did it start? _____ When did it start? _____

What is your current level of discomfort? Slight 1 2 3 4 5 6 7 8 9 10 Severe N/A

What is your discomfort at its worst? Slight 1 2 3 4 5 6 7 8 9 10 Severe N/A

Approximately when was it last at its worst? _____

Is there a time during the day when your symptoms are worse? _____

What do you do to try to alleviate your condition? _____

Does it work for you? _____ What makes it worse? _____

If any, what medications are you taking for your condition? _____

Have you received a diagnosis from a doctor? _____

Please indicate on the diagram the nature of your symptoms, using the symbols indicated:

Aching **O**

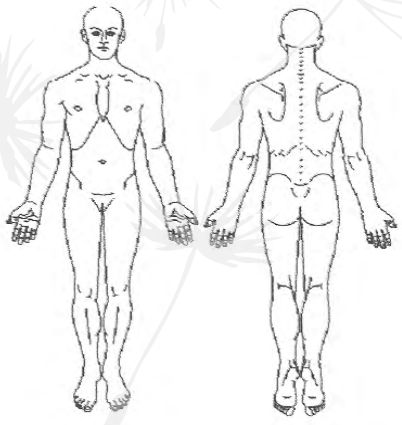
Stabbing **X**

Shooting →

Burning **#**

Numbness **~~**

or Tingling



List any Activities, Sports, Hobbies
(ie. Jogging, Hockey, Crafts, Computer, etc)

_____

_____

_____

Please indicate with a **C** for **Current** and **P** for **Past** conditions that you have or had:

__ High Blood Pressure	__ Dizziness	__ Bruising	__ Crohns/Colitis
__ Heart Conditions	__ Fainting	__ Cold hands/feet	__ Constipation
__ Shortness of Breath	__ Weakness	__ Varicose veins	__ Diarrhea
__ Headaches	__ Concussions	__ Cancer	__ Epilepsy
__ Jaw pain	__ Depression	__ Arthritis	__ Parkinson's
__ Tinnitus	__ Fatigue	__ HIV/AIDS	__ MS
__ Fractures	__ Allergies	__ Diabetes	__ Scoliosis
__ Dislocations	__ Sinus trouble	__ Osteoporosis	__ Stroke
__ Artificial Joints	__ Blurry vision	__ Skin conditions	__ Anxiety

Are you satisfied with your current: (1 = not at all, 5 = completely satisfied)

Ability to work	1 2 3 4 5
Level of exercise	1 2 3 4 5
Diet	1 2 3 4 5
Sleeping patterns	1 2 3 4 5
Energy level	1 2 3 4 5
Emotional status	1 2 3 4 5

Hours of sleep per night (approx.) _____
Number of meals you regularly eat per day _____
Number of times you exercise per week _____

Do you:

Wear orthotics? Yes No If yes, what for? _____
Wear a dental appliance? Yes No If yes, what for? _____
Sleep on your Back Side Stomach

Please list any **major accidents, illnesses or medical procedures.**

_____
_____
_____
_____

Do you take any **medications, herbal supplements or vitamins/minerals?**

Please list:	Reason:
_____	_____
_____	_____
_____	_____

Are you currently receiving treatment from any of the following health professionals?

Doctor___ Naturopath___ Chiropractor___ Physiotherapist___ Acupuncturist___

Have you had massage therapy before? _____ If yes, when? _____

What for? _____

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 the appointment fee will be charged. Payment for all treatment, whether private or insured, is ultimately the responsibility of the patient.

I give permission for the clinic to leave messages regarding appointments at any of the contact numbers I have provided above.

The information on this form is correct to the best of my knowledge and provides an accurate summary of my past and present medical status. I hereby give my consent to receive massage therapy at Burnaby Heights Integrative HealthCare Inc. and I assume the financial responsibility for all treatments I receive.

Patient (or guardian) signature _____ **Date:** _____

BURNABY HEIGHTS
Integrative
HEALTHCARE

For Patients with Extended Health Benefits
Insurance Providers include: Great-West Life, Sun Life, Standard Life, Johnson Inc., Industrial Alliance, Chamber of Commerce, Maximum Benefit, Manulife, Desjardins, and Blue Cross

Benefit Assignment Form

Insurance Company**:** _____

Patient Name: _____ Date of Birth: _____

Policy Number: _____

Member ID Number: _____

If you are not the insured member, then please provide insured member name and date of birth.

Insured Member Name: _____ Date of Birth: _____

I hereby assign benefits payable for the eligible claims to the **Burnaby Heights Integrative HealthCare, Inc (the Provider)** responsible for submitting my claims electronically to the group benefits plan and I authorize the insurer/plan administrator to issue payment directly to the Provider. In the event my claim(s) are declined by the insurer/plan administrator, I understand that I remain responsible for payment to the Provider for any services rendered and/or supplies provided.

I acknowledge and agree that the insurer/plan administrator is under no obligation to accept this Assignment, that any benefit payment made in accordance with this Assignment will discharge the insurer/plan administrator of its obligations with respect to that benefit payment, and that in the event the benefit payment is made to me, the insurer/plan administrator will also be discharged of its obligation with respect to that benefit payment.

I understand that this Assignment will apply to all eligible claims submitted electronically by the Provider and that I may revoke it at any time by providing written notice to the insurer/plan administrator.

If I am a spouse or dependent, I confirm that I am authorized by the plan member to execute an assignment of benefit payments to the Provider.

Credit Card: Visa/Mastercard: _____ Exp:_____

Date: _____

Signature: _____ Print Name: _____

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