SUNSET PHYSIOTHERAPY

Massage Patient Information

Last name: _____ First name: _____

Date of Birth: month____/day____/year_____ Occupation: _____

CareCard Number: _____

Address: _____ City: _____

Postal Code: _____ Home Phone#: _____

Cell#:/carrier: _____ Work#: _____

Email: _____

Family Doctor: _____ Phone#: _____

Fax#: _____

ICBC Claim#: _____ **Date of Injury**: _____

Adjuster: _____ Phone#: _____

Adjuster's Email: _____ Fax#: _____

How long have you had this condition? _____

How did it start? _____

What makes it worse? _____

What makes it better? _____

Have you received other treatment for any of this condition? YES or NO

If yes, what kind of other treatment? _____

Family History: High Blood Pressure Heart Disease Stroke Cancer Diabetes Osteoporosis

Please list any medications you presently take: _____

Any major accidents, illnesses, or surgeries ? _____

Known Allergies: _____

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Massage Patient Information

Please indicate if you believe any of the following apply to you: (P=PAST C=CURRENT)

Heart Attack	Nausea	Arthritis
High/Low Blood Pressure	Spinal Injury	Osteoporosis
Stroke or Aneurysm	Head Injury	Rods/Pins/Plates
Pace Maker	Epilepsy/Seizures	Implants
Other Heart Conditions	Other Neurological Condition	Transplants
Varicose Veins	Asthma	Cancer
Bruise easily	Chronic Sinusitis	Hepatitis
Other Circulatory Condition	Other Respiratory Condition	HIV
Diabetes	Irritable Bowel/Colitis	Other Contagious Conditions
Kidney Disease	Digestive Condition	
Other Urinary Condition	Skin Condition	
Headaches/Migraines	Joint Dislocation	
Dizziness/Fainting	Bone Fracture	

I_____ authorize the clinic and its associated Registered Massage Therapist to collect my personal information as documented above in order to contact me.
I give my permission for the clinic to leave messages regarding appointments at any of the contact numbers I have provided above. In addition, I authorize the clinic and associated Registered Massage Therapists 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.

Please Note: Your appointment time has been reserved for you. In courtesy of your therapist and fellow patients, we ask you to provide us with 24 hour notice of cancellation, or a **$25 cancellation fee** will be charged.

_____ _____

Date Patient's Signature

CONSENT TO TREAT A MINOR CHILD:
I hereby authorize this therapist to administer care as deemed necessary for my child.

_____ _____

Date Parent/Legal Guardian's Signature

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Authorization for Release of Information

I _____ hereby authorize Sunset Physiotherapy associated therapists to release information pertaining to my physical condition, treatment, and progress to the following people or organizations only:

FAMILY PHYSICIAN_____

ICBC_____

WCB_____

OTHER_____

Registered Massage Therapists use manual techniques and are required to advise patients that there are or may be some risks associated with such treatments.

I_____ hereby authorize and grant permission to all registered massage therapists at Sunset Physiotherapy Clinic to carry out any assessment, examinations, treatments and procedures as maybe necessary to treat my condition or injury.

I_____ acknowledge and agree that all registered massage therapists will not be liable for any loss or injury, claim or damage resulting from or connected with receiving massage therapy from Sunset Physiotherapy Clinic, UNLESS such loss claims, liabilities or damage results from the gross negligent from any of the massage therapists at this clinic.

_____ _____

Date Patient's Signature

CONSENT TO TREAT A MINOR CHILD:

I hereby authorize this therapist to administer care as deemed necessary for my child

_____ _____

Date Parent/Legal Guardian's Signature