ChiroPhysio GATINEAU

Besma Berkat
Registered Massage Therapist
91 rue Laval, Gatineau, QC, J8X 3H4
Tel.: (819) 771-8700 • Fax. : (819) 771-8683

Health Assessment

As an orthotherapist/massage therapist, I will conduct my business as it is explained in their Code of Ethics. Therefore, the contents of this assessment will be kept private and will only be shown to any third party with the client's authorization. I will constantly improve the quality of my services and operations and will create a reputation for honesty, fairness, respect, responsibility, integrity, trust and sound business judgment.

Personal Information

☐Mrs. ☐Mr. Name: _____ Surname: _____

Address: _____

Ville : _____ Zip Code : _____

Phone Home/Cell.: _____ Email : _____

Birthdate (DD/MM/YYYY): _____ Occupation: _____

Did a health care practitioner refer you for a massage therapy? ☐ Yes ☐ No

If yes, please provide their name and address; _____

Do you need an insurance receipt? ☐ Yes ☐ No

Is this your first massage? ☐ Yes ☐ No

Are you receiving treatment such as: ☐ Physiotherapy ☐ Osteopathy ☐ Acupuncture ☐ other: _____

Do you practice any sports? If so, which sport(s) and how many times per week? _____

_____

Any allergies or hypersensitivities? ☐ Yes ☐ No To what? _____

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Current medications and conditions they are treating

_____

_____

_____

Surgeries/ Injuries including dates

_____

_____

_____

Reason for initial visit

_____

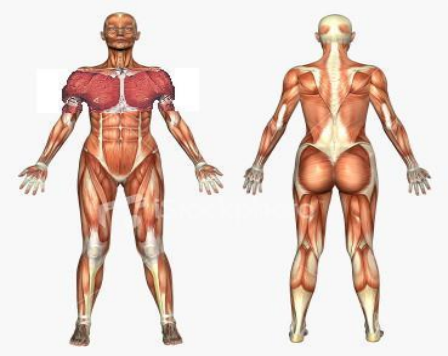
_____

_____

_____

_____

Indicate the area of tension



Please check the items that concern you:

HEAD NECK

- ○ Headache/migraines
- ○ Ringing in ears
- ○ Vision problems
- ○ Vertigo / dizziness
- ○ Hearing loss
- ○ Vision loss

CARDIOVASCULAR

- ○ High blood pressure
- ○ Heart attack
- ○ Heart disease
- ○ Phlebitis /varicose
- ○ Hemophilia
- ○ Chronic congestive heart failure
- ○ Family history of cardiovascular problems
- ○ Low blood pressure
- ○ Stroke
- ○ Poor circulation
- ○ Pacemaker

OTHER CONDITIONS

- ○ Cancer
- ○ Diabetes
- ○ Fibromyalgia
- ○ Digestive conditions
- ○ Unexplained weight loss
- ○ chronic fatigue syndrome
- ○ Depression
- ○ Anxiety
- ○ Other conditions _____

_____

_____

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RESPIRATORY

- ○ Asthma
- ○ Chronic cough
- ○ Emphysema
- ○ Frequent colds
- ○ Family history of respiratory difficulties
- ○ Shortness of breath
- ○ Bronchitis
- ○ Sinusitis
- ○ Smoker

MUSCULOSKELETAL SYSTEM

- ○ Arthritis
- ○ Osteoporosis
- ○ Bursitis /Tendonitis
- ○ Family history of arthritis
- ○ Jaw pain (TMJ)
- ○ Pins / plates / wires / artificial joint

NERVOUS SYSTEM

- ○ Sensory loss / change
- ○ Sciatica
- ○ Seizures
- ○ Numbness / tingling
- ○ Epilepsy
- ○ Multiple sclerosis

WOMEN

- ○ Pregnant. Due date _____
- ○ Gynecological problems _____
- ○ Date of menstruation _____

SKIN & INFECTIONS

- ○ Hepatitis
- ○ Herpes
- ○ Lyme disease
- ○ HIV / AIDS
- ○ Tuberculosis
- ○ Infections skin conditions

Consent for Massage Therapy

I understand that the massage I receive is provided for the basic purpose of relieving muscular tension, relieving pain and facilitating range of motion and relaxation. If I experience any pain or discomfort during the session, I will immediately inform the therapist so that the pressure and/or strokes may be adjusted to my level of comfort. I further understand that massage should not be construed as a substitute for medical examination, diagnosis, or treatment. I understand that massage therapists are not qualified to perform spinal or skeletal adjustments, diagnose, prescribe, or treat any physical or mental illness, and that nothing said during the session given should be construed as such.

Because massage should not be performed under certain medical conditions, I affirm that I have stated all my known medical conditions and answered all questions honestly. I agree to keep the massage therapist updated as to any changes in my medical profile during the session and understand that there shall be no liability on the massage therapists' part should I fail to do so.

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I understand that any illicit or sexually suggestive remarks or advances made by me will result in immediate termination of the session. I also understand that the license mas sage therapist reserves the right to refuse to perform massage on anyone whom he/she deems to have a condition for which massage is contraindicated.

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. In addition, I intend this consent to cover the treatment discussed with me and such additional treatment as performed by my massage therapist from time to time to deal with my physical condition for which I have sought massage therapy. I understand that at any time I may withdraw my consent and massage therapy will be stopped.

cancellation policy

Your care is very important to this office and as a result, an appointment time is reserved for your treatment. If it's necessary to reschedule or cancel an appointment, please provide the office with 24 hours notice.
If an appointment is **cancelled** or **rescheduled** with **less than 24 hours notice**, the full treatment fee will be charged to the patient, and in this case an insurance receipt will not be issued. If the treatment is rescheduled for the same business day, this fee will be waived (rescheduling for the same day is dependent upon therapist availability).

Thank you for respecting your therapist's time and agreeing to this policy.

I, _____ have read the above information and understand my rights to consent of treatment.

Signature: _____ Date: _____