

LEGACY THERAPEUTICS
Move Better – Feel Better – Perform Better

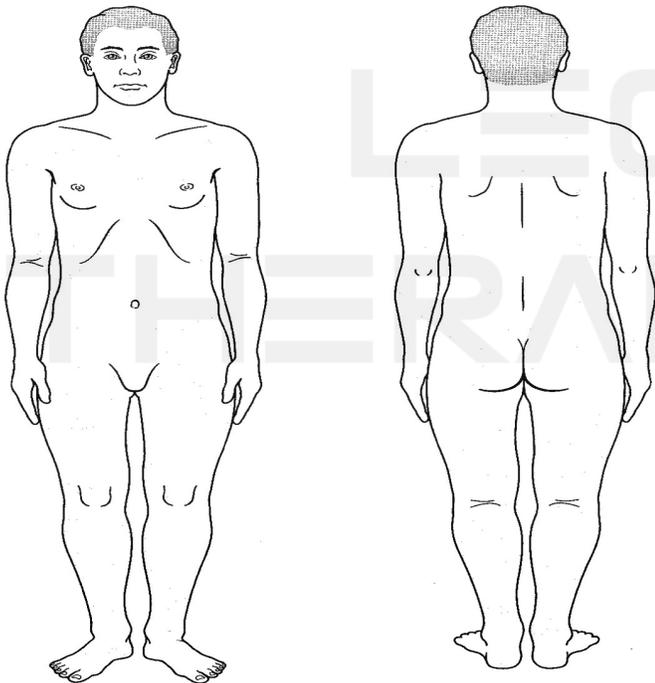
CLIENT INFORMATION AND CONSENT FORM

FYI: An accurate health history ensures that it is safe for you to receive a massage treatment, and helps the therapist determine a proper treatment plan. When your health status changes in the future, please let us know. All information gathered on this form is confidential. Your written authorization is legally required before any of this information can be released.

Name: _____
Occupation: _____
Phone Numbers: Home: _____ Cell: _____ Work: _____
Email Address: _____
Address: _____
Postal Code _____
Date of Birth: _____
Emergency contact name: _____ Cell: _____
How did you hear about us? _____
Physician's name/Phone number & address (if you know it) _____

Insurance Provider: _____ Plan/Group/Contract # _____ Certificate #: _____
Are you the primary insured person (PIP) on this plan?
If not, please provide name and DOB of the PIP:
By providing us with your insurance information, you authorize us to direct bill your insurance provider on your behalf for any services rendered.

What is your major area of concern that you would like treated? (Write below & circle the areas)



On the body diagrams to the left, please circle the areas that you are experiencing problems/pain/stiffness etc. If you are experiencing pain in one area and feeling it elsewhere, please indicate this with arrows.

Is there any area that you would like the therapist to avoid working on:

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Please indicate all conditions you have experienced. Mark **C** for current or **P** for past.

Joint/Soft Tissue Discomfort:

- Arms
 - Upper Back
 - Mid Back
 - Lower Back
 - Degenerative Discs
 - Feet
 - Hands
 - Hips
 - Jaw
 - Knees

 - Legs
 - Neck
 - Osteo Arthritis
 - Rheumatoid Arthritis
 - Limitation of Movement
 - Shoulders
- In which joints: _____
- Other _____

Cardiovascular:

- High Blood Pressure
- Low Blood Pressure
- Coronary Heart Disease
- Heart Attack
- Stroke / CVA
- Pacemaker
- Heart Murmur
- Palpitations
- Varicose Veins
- Swelling of the Ankles
- Poor Circulation

Eye, Ear, Nose, Throat:

- Allergies
- Frequent Colds
- Glasses or Contacts
- Hearing Loss
- Sinus Infection
- Swollen Glands

Skin:

- Rashes
 - Itching
 - Bruise Easily
 - Dryness
 - Boils
- Other _____

General Symptoms:

- Fainting
- Dizziness
- Loss of Sleep

- Fatigue
- Nervousness
- Sudden Weight Loss/Gain
- Numbness
- Paralysis
- Headaches (Tension)
- Migraines

Infectious:

- Hepatitis
 - Tuberculosis
 - Human Immunodeficiency Virus (HIV)
 - Herpes
 - Cold
 - Athlete's Foot
 - Warts
- Other _____

Digestive:

- Poor Appetite
- Belching/Gas
- Constipation
- Diarrhea
- Nausea
- Ulcer
- Vomiting

- Diabetes (Type 1 or 2)

Respiratory:

- Chronic Cough
- Bronchitis
- Asthma
- Hay Fever
- Difficulty Breathing
- Smoking
- Emphysema
- Pneumonia

For Women:

Reproductive:

- Pregnant
- Due date _____
- Painful Menstruation
- Heavy Flow
- Irregular Cycle
- Menopausal
- Pre-menopausal
- Post-menopausal
- Birth control
- type _____

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Lifestyle Questions

Do you take prescribed medications: Yes No

Frequency: _____
Type: _____

Regular exercise: Yes No

Type: _____ Frequency: _____

High Stress Yes No

Allergies/Hypersensitivities: _____

Have you received care from any of the following? (circle)

- Physiotherapist
- Chiropractor
- Massage therapist
- Naturopath
- Other:

Have you had surgery in the past? If yes, for what? _____

Have you had any fractures/sprains in the past? If yes, where? _____

Have you had any serious illnesses in the past? If yes, what? _____

Did the current injury result from a motor vehicle accident or workplace injury? Yes No

I attest that the information I have provided is true and complete to the best of my knowledge.

I understand the information I have provided on this form is confidential and will not be released without my written consent.

I consent to therapeutic massage treatment by one of the therapists of Legacy Therapeutics.

I hereby assign benefits payable for the eligible claims to 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.

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INFORMED CONSENT TO MASSAGE THERAPY TREATMENT

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

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, 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, only when necessary and only with a prior verbal request.

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.

**WHEN YOU BOOK AN APPOINTMENT, THAT TIME IS SET ASIDE FOR YOU, AND MISSED APPOINTMENTS PREVENT US FROM ACCOMMODATING OTHER CLIENTS. IF YOU DO NOT SHOW UP FOR YOUR SCHEDULED APPOINTMENT OR IF YOU WANT TO RESCHEDULE, AND YOU HAVE NOT NOTIFIED US AT LEAST 24 HOURS IN ADVANCE, YOU WILL BE REQUIRED TO PAY THE FULL COST OF THE TREATMENT AS BOOKED. MISSED APPOINTMENT FEES ARE NOT TO BE DIRECT BILLED. WE CAN GIVE YOU A RECEIPT FOR THE SERVICE YOU HAVE LATE CANCELLED OR MISSED THAT YOU ARE WELCOME TO SUBMIT TO YOUR INSURANCE PROVIDER.*

Patient Name _____

Signature of Patient/Guardian _____

Date Signed _____