

# Lee McGuire, R.M.T.

Registered Massage Therapist

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Print Form

NAME:  SEX: FEMALE  MALE:

ADDRESS:  BIRTHDATE: (yy/mm/dd)

CITY:  EMAIL:

POSTAL CODE:  OCCUPATION:

HOME PHONE:  WORK PHONE:  MOBILE PHONE:

MSP CARE CARD NUMBER:  DOCTOR'S NAME:

DOCTOR'S REFERRAL: Yes  No  DOCTOR'S PHONE:

## ICBC

CLAIM NUMBER:  MVA DATE:

ADJUSTERS NAME:  ICBC LOCATION:

ADJUSTERS PHONE:  ICBC FAX NUMBER:

LAWYER NAME:  LAWYER'S PHONE:

HAVE YOU RECEIVED MASSAGE THERAPY, PHYSIOTHERAPY, CHIROPRACTIC OR PODIATRY THIS YEAR? Yes

No

ARE YOU TAKING ANY MEDICATIONS? Yes  No

IF YES, WHICH MEDICATIONS AND WHAT FOR?

HAVE YOU HAD ANY ACCIDENTS, SURGERIES OR ILLNESSES RELATED TO YOUR CURRENT CONDITION? Yes

No

IF YES, PLEASE EXPLAIN:

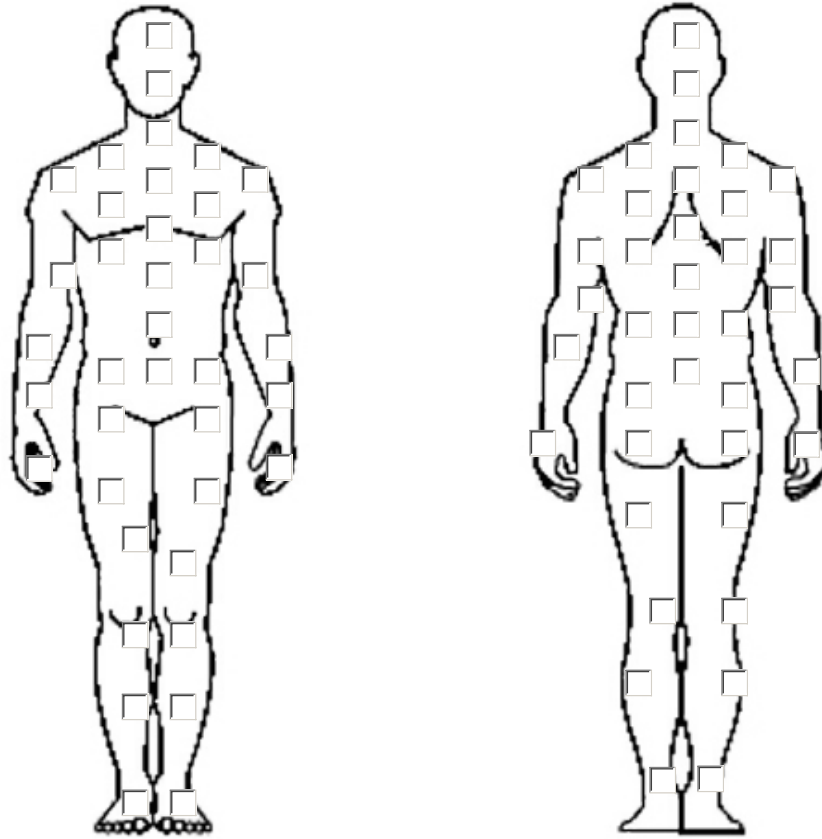
HOW WERE YOU REFERRED TO OUR CLINIC?  DOCTOR  FRIEND  SUPERPAGES  GOOGLE  
 MY WEB SITE  CLINIC WEB SITE

## **CANCELLATION POLICY**

**IF YOU NEED TO CANCEL AN APPOINTMENT PLEASE DO SO AT LEAST (24)TWENTY FOUR HOURS PRIOR TO THE DATE OF YOUR APPOINTMENT. ANY APPOINTMENTS NOT CANCELLED WITHIN 24 HOURS WILL BE SUBJECT TO A CANCELLATION FEE ACCORDING TO THE REGULAR APPOINTMENT FEE'S. (ie. \$75.00 for a 60 minute appointment) IF YOU MISS AN APPOINTMENT WITHOUT ANY NOTICE OF CANCELLATION, YOU WILL BE BILLED ACCORDING TO THE REGULAR APPOINTMENT FEE'S (ie. \$75.00 for a 60 minute appointment)**

**CHECK HERE TO INDICATE YOU AGREE TO THE CANCELLATION POLICY**

**PLEASE INDICATE PROBLEM AREA WITH AN X**



**PLEASE MARK PAST AND CURRENT CONDITIONS WITH AN X**

- |   |   |  |
|---|---|--|
| <input type="checkbox"/> HEART ATTACK           | <input type="checkbox"/> LIVER PROBLEMS             | <input type="checkbox"/> OSTEOPOROSIS    |
| <input type="checkbox"/> HIGH BLOOD PRESSURE    | <input type="checkbox"/> PINS/NEEDLES IN ARMS/HANDS | <input type="checkbox"/> ANEMIA          |
| <input type="checkbox"/> SWOLLEN ANKLES         | <input type="checkbox"/> GRINDING/GRATING IN NECK   | <input type="checkbox"/> HIV POSITIVE    |
| <input type="checkbox"/> LOW BLOOD PRESSURE     | <input type="checkbox"/> PINS/NEEDLES IN LEGS/FEET  | <input type="checkbox"/> RHEUMATIC FEVER |
| <input type="checkbox"/> FAINTING OR DIZZINESS  | <input type="checkbox"/> SLIPPED DISC/HERNIATION    | <input type="checkbox"/> POST POLIO      |
| <input type="checkbox"/> KIDNEY TROUBLE         | <input type="checkbox"/> FRACTURES/DISLOCATIONS     | <input type="checkbox"/> HEADACHES       |
| <input type="checkbox"/> CANCER                 | <input type="checkbox"/> SHORTNESS OF BREATH        | <input type="checkbox"/> STOMACH TROUBLE |
| <input type="checkbox"/> MULTIPLE SCLEROSIS     | <input type="checkbox"/> SLEEPING PROBLEMS          | <input type="checkbox"/> GOUT            |
| <input type="checkbox"/> NEUROLOGICAL CONDITION | <input type="checkbox"/> COLD FEET/HANDS            | <input type="checkbox"/> DEPRESSION      |
| <input type="checkbox"/> STROKE                 | <input type="checkbox"/> JAW CLICKING PAIN          | <input type="checkbox"/> ASTHMA          |
|   | <input type="checkbox"/> DIABETES                   | <input type="checkbox"/> PAINFUL JOINTS  |

**I BELIEVE THE INFORMATION ON THIS FORM TO BE CORRECT AND HAVE COMPLETED THE FORM TO PROVIDE AN ACCURATE SUMMARY OF MY PAST AND/OR PRESENT MEDICAL CONDITION. I ALSO AGREE TO THE CANCELLATION POLICY STIPULATED HEREIN. I THE UNDERSIGNED AUTHORIZE MASSAGE THERAPY TREATMENTS TO BE RENDERED UPON MY PERSON AND I ASSUME FINANCIAL RESPONSIBILITY FOR THE TREATMENTS AND FOR ANY MISSED OR CANCELLED APPOINTMENTS.**

**SIGNATURE**

**DATE**