WAIVER & CONSENT FORM

I, _____, understand that the manual therapy I receive is provided for the basic purpose of working with myofascial or soft tissue to alleviate muscle knots that could have possible connections to referred pain. I further understand that the manual therapy should not be construed as a substitute for medical examination, diagnosis, or treatment and that I should see a physician, chiropractor, or other qualified medical specialist for physiological or physical ailment that I am aware of.

I understand that the manual therapist is not qualified to perform skeletal adjustments, diagnose and/or prescribe, and that nothing said in the course of the session should be construed as such. Since manual therapy is contraindicated under certain conditions, I affirm that I have stated all my known medical conditions and answered all questions honestly. I agree to keep the therapist updated as to any changes in my medical profile and understand that there shall be no liability on the therapist's part should I forget to do so.

All personal information is kept confidential.

EXPLANATION OF FEES

The purpose of this page is to clarify your financial responsibilities so that we focus our efforts on helping you achieve optimal results in the shortest possible amount of time.

Forms of Payment: Patients are responsible for full payment at the time services are rendered. We accept personal cheque and cash. Any credit arrangements must be authorized in advance by the office.

Third Party Insurance Coverage: Third party insurance or extended health care benefits coverage varies from plan to plan. Please check with your provider for specific coverage details. All professional services rendered are charged to the patient receiving care. We will supply you with statements, reports, or other documents for a fee (if applicable) as outlined above, to help you receive reimbursement from a third party.

Missed/Cancellation Appointments: Our office requires 24 hour notice cancellation of any appointment. Appointments missed or cancelled without sufficient notice will be charged the cost of treatment.

PATIENT INFORMATION

First Name: _____ Last Name: _____

Occupation: _____

Medical Doctor: _____

Home Address: _____

Postal Code: _____

Phone: (H) _____ (B) _____

Phone: (C) _____

Date of Birth: _____/_____/_____ (day/month/year) Age:_____

Sex: M F

E-Mail Address: _____

Best method to contact you: ◯ Home Phone ◯ Bus Phone ◯ Cell Phone ◯ Text ◯ E-Mail

MISSED APPOINTMENT AUTHORIZATION

If any appointment is missed, I consent BH Manual Therapy to charge my credit card.

CC# _____ Expiry date:_____

Patient /Guardian signature: _____

I have read, understood, and agreed to the fees and payment obligations as listed above.

Patient/Guardian Name _____ Date _____
(Please Print)

Patient/Guardian Signature _____

◯ Please check if you would like to be on our mailing list, receive updates on workshops, wellness tips or newsletters.

QUESTIONNAIRE

1. Do you suffer from any of the following?

◯ diabetes	◯ joint diseases	◯ heart problems
◯ kidney disease	◯ high blood pressure	◯ respiratory disease
◯ areas of numbness	◯ paralysis / tingling sensations	◯ skin disease
◯ infectious disease	◯ migraines / tension headaches	◯ joint or muscle injuries
◯ areas of chronic pain	◯ digestive disease / problems	

Please list any other conditions not mentioned:

_____

_____

_____

2. Are you taking medication? Y or N

If yes, please list: _____ _____ _____

_____ _____ _____

3. Have you ever had local steroid injections for inflammation or other acute pain? Y or N

If yes, please list: _____ _____ _____

_____ _____ _____

4. Do your muscles cramp easily or often? Y or N

5. Which muscles in your body usually suffer from tension, soreness, etc.

◯ back	◯ arms	◯ wrists
◯ neck	◯ chest	◯ hips
◯ shoulder	◯ legs	◯ jaw

6. Which joints are often stiff and sore? _____

_____

_____

7. Are there any areas of your body you would feel uncomfortable having massaged?

If yes, please list: _____

_____

8. Have you suffered from any accidents, trauma, or surgeries? Y or N

   If yes, please list: _____ _____ _____

   _____

9. Have you undergone treatment from other health care professionals? Y or N

   If yes, please list: _____ _____ _____

   _____

10. Did you feel that there were improvements from these treatments? Y or N

    Please specify: _____

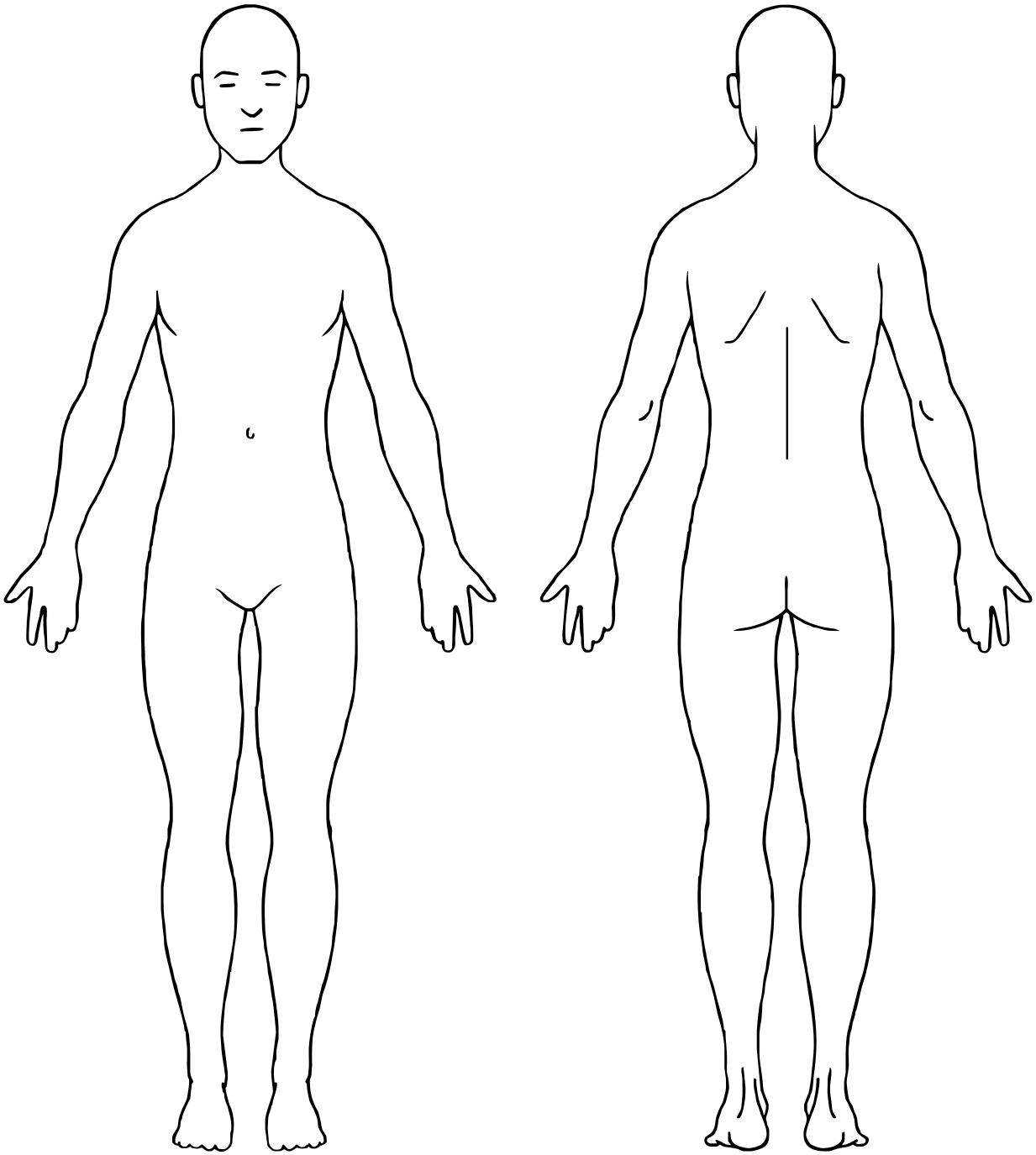
    _____

    _____

BODY CHART

Please indicate areas of pain, discomfort or unusual feelings on this body chart. *(Please use the appropriate symbols)*

◯ = **Pain Areas** ✕ = **Joint & Muscle Stiffness** ≋ = **Numbness, Tingling or Altered Sensation Areas**



Additional comments: _____

_____

_____