Robynne Ouchi RMT

3803 27th St Vernon BC V1T 4B6

POLICIES & WAIVER FORM

1. **Initial visit** will include: completion of case history, and as needed, blood pressure reading and assessments. You, the client, **can refuse treatment**, alter treatment or terminate treatment at *any time* .

2. For the benefit of all clients, it is requested perfumes, colognes and other **scents** not be used in consideration of others who may be allergic or sensitive.

3. **Appointment times** will start and end as scheduled. If you are late the treatment will not extend past the time it was originally booked for. This is to honor ALL of the client times that have been booked for through out the day.

4. The clinic **cancellation policy** states that if cancellations are not reported in advance of 24 hours of the appointment, full cost of treatment may be rendered. This is to assist emergency requests who are on the waiting list receive expedient care.

5. **Homecare** is the responsibility of the client. Without compliance, goals and expectations as well as general comfort will be altered significantly. It is strongly recommended that homecare is taken very seriously if clients are serious about improving their current conditions.

6. I recognize that **my therapist and I are partners in my health care** program and I agree to take responsibility for my health and lifestyle choices. I understand that this form of therapy is not intended to replace the need for other appropriate professional health care for serious conditions. Please note that all information provided on your health history will be kept confidentially unless allowed or required by law. Your written permission will be required to release any information.

7. **Gift certificate policy** states any gift certificate not redeemed within one year reverts back to the purchaser.

I acknowledge that my treatment is subject to the above conditions, and agree to the above conditions, and understand everything be explained to me and I consent to treatment.

Signed	Date

ANNUAL UPDATES

Robynne Ouchi RMT

HEALTH HISTORY FORM

Please complete this form in full. All information is strictly confidential. These questions will help determined the safety and efficacy of the massage therapy treatment.

Date: _____

Name: _____ Date of Birth: _____
Last First

Occupation: _____

We bill to most extended health care plans. To authorize direct billing please complete below.
Insurance companies periodically call service providers for fraud prevention. Pls check here is you do not allow us to answer fraud prevention questions without contcting you first. ☐

Insurance provider _____ Plan # _____ Policy/ID # _____

Name on Plan _____ If spouse - pls list spouse date of birth _____

Current complaint: _____

Goals & expectations _____

_____

Resident Address: _____
Street City

Province: _____ Postal Code: _____ Email _____

Resident Telephone Number: _____ Business Number : _____

General Practitioner: _____ Address: _____ Phone: _____

Date of last medical exam: _____ **How did you hear about us?** _____

List any past surgeries incl. dates

_____
_____
_____
_____
_____

List any past accident incl. dates

_____
_____
_____
_____
_____

Please list all medications you are currently taking - or within the last 6 months

Medication Reason for taking it

_____
_____
_____
_____
_____

Have you taken any pain killers or anti inflammatories in the past 2 hours? **Yes/No**

HEALTH HISTORY cont.

Are you currently or have you had any previous treatments for the above complaint's) by:

☐	Medical doctor	☐	Acupuncture
☐	Chiropractor	☐	Physio therapist
☐	Massage therapist	☐	Other

Do you exercise regularly (3 times per week 30 min or more) ☐ Yes ☐ No

PLEASE CHECK ANY PAST OR CURRENT HEALTH PROBLEMS:

Head/neck
- ☐ headache
- ☐ migraine
- ☐ above with aura
- ☐ vision problems
- ☐ dizziness
- ☐ earaches/ringing ears
- ☐ hearing problems
- ☐ herniated disc

Respiratory
- ☐ asthma
- ☐ chronic cough
- ☐ shortness of breath
- ☐ bronchitis/pneumonia
- ☐ emphysema
- ☐ fever or flu
- ☐ allergies/sinus problems
- ☐ anaphylaxis

Skin
- ☐ skin condition
- ☐ bruise easily
- ☐ plantar warts
- ☐ rashes/itching
- ☐ loss of sensation
- ☐ eczema/psoriasis

Digestive
- ☐ difficult digestion
- ☐ constipation
- ☐ liver/gall bladder
- ☐ kidney/bladder
- ☐ Chrone's disease/colitis
- ☐ gas pain/abdominal pain
- ☐ ulcers
- ☐ diabetes/hypoglicemia

Female
- ☐ pregnancy (current/previous)
- ☐ menopausal problems
- ☐ menstrual problems

Cardiovascular
- ☐ High blood pressure
- ☐ low blood pressure
- ☐ poor circulation
- ☐ heart disease
- ☐ shortness of breath
- ☐ phlebitis
- ☐ varicose veins MD diagnosed
- ☐ chronic congestive heart failure
- ☐ stroke
- ☐ heart attack
- ☐ pacemaker
- ☐ aneurysm
- ☐ dizziness

Muscle/joint
- ☐ neck
- ☐ low back
- ☐ mid back
- ☐ upper back
- ☐ shoulders
- ☐ hip
- ☐ knee
- ☐ ankle
- ☐ cold/sweaty hands/feet

HEALTH HISTORY cont.

- [ ] anxiety/depression/insomnia
- [ ] hemophilia
- [ ] epilepsy
- [ ] frequent colds/fatigue
- [ ] fibromyalgia
- [ ] osteoporosis
- [ ] chronic fatigue syndrome
- [ ] polio/post polio
- [ ] scoliosis
- [ ] carpal tunnel syndrome
- [ ] cancer
- [ ] arthritis

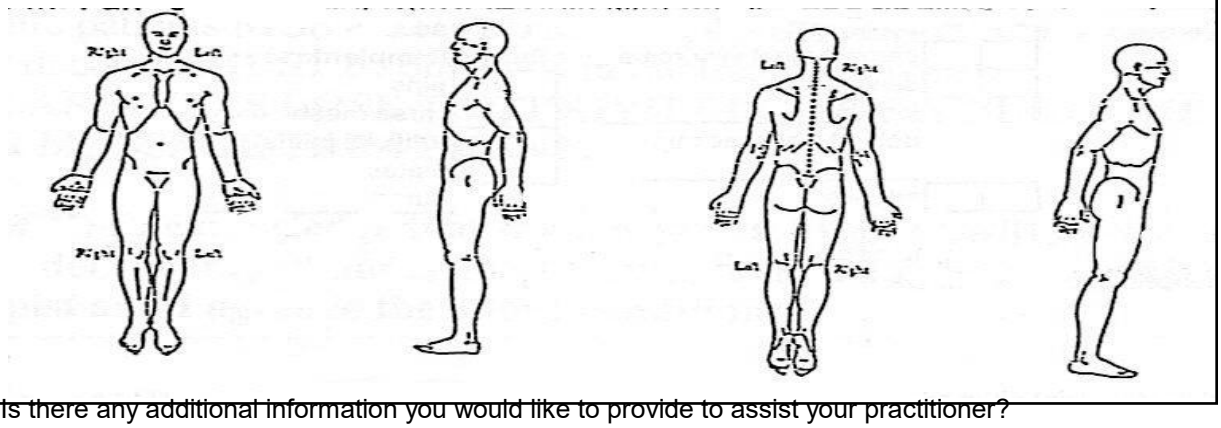
- [ ] Surgical implants
- [ ] pins
- [ ] wires/mesh
- [ ] artificial joints
- [ ] plates
- [ ] other
- [ ]
- [ ] infective conditions
- [ ] Tuberculosis yes no onset
- [ ] AIDS/HIV yes no onset
- [ ] Hepatitis yes no onset
- [ ] Infectious skin cond. yes no onset

- [ ] anemia
- [ ] parasites
- [ ] chicken pox
- [ ] measles

Please check conditions experienced now and in the past:

- [ ] muscle strain/ligament sprain
- [ ] tendinosis/fibrosis/bursitis
- [ ] fracture
- [ ] whiplash
- [ ] other

Please mark areas of pain (with an X) on the figures



Is there any additional information you would like to provide to assist your practitioner?

_____

_____

_____

I certify that the information given in this form is true and accurately reflects my past and present health status.

Signature _____ Date: _____