METROTOWN
MASSAGE THERAPY

Last Name	First Name	Email Address		
Is this your preferred name? ❑ Yes ❑ No	If No, please indicate your preferred name.	Birth date (MM.DD.YY)	Age:	Gender:
Apt #:	Address:	Cell Phone # ( )		
City: Province: Postal Code:		Personal Health Number (PHN):		
Occupation:	Employer:	Work Phone Number ( )		

Referred to clinic by (please check one box): ❑ Dr. _____ ❑ Google ❑ Yelp

❑ Friend/Family Member: _____ ❑ Close to home/work ❑ Other: _____

Primary reason for visit (Please Describe):

EXTENDED HEALTH INFORMATION

Extended Health Insurance Provider: ❑ Canada Life ❑ Sunlife ❑ Pacific Blue Cross ❑ Manulife ❑ Other: _____

Policy/Plan Number: _____ Member ID: _____

Name of the Primary Card Holder: Birthday of Primary Card Holder (MM.DD.YR):

_____ _____

Is today's visit related to an ICBC motor vehicle accident?
❑ Yes
❑ No
If **YES**, please list the following:

Date of the Accident (MM.DD.YR): _____

Claim Number: _____

Adjuster Name: _____

Adjuster Phone Number: _____

EMERGENCY CONTACT

Name of local friend or relative:	Relation to patient:	Home phone no.:	Work phone no.:
		( )	( )

MISSED APPOINTMENT POLICY + MSP ASSIGNMENT

I understand that I am financially responsible for medical services provided to me and for missed appointments. If I am unable to keep an appointment, I must notify the clinic at least 1 business day in advance to avoid being charged the full amount of the treatment. For Monday appointments, I understand that I must provide notice by 3:00 PM on the Saturday prior, as it is considered a business day and the clinic closes at that time. There are three ways to modify or cancel an existing appointment:

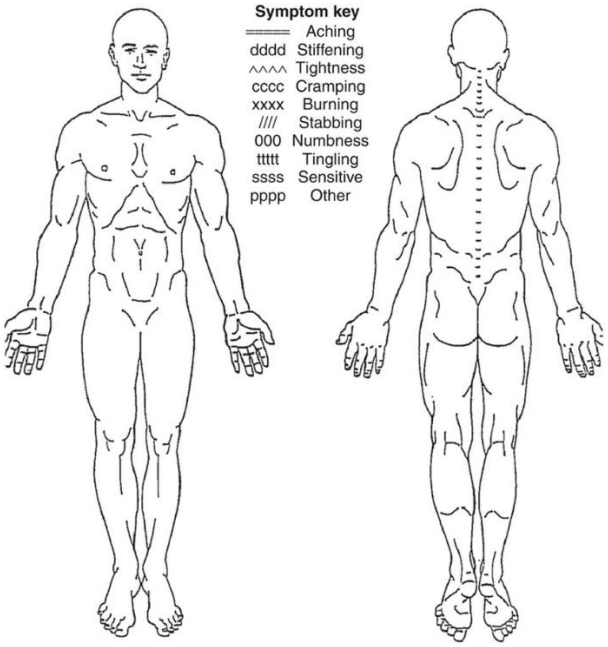
1. Call OR text the clinic: 604-430-1525
2. Email info@metrotownwellness.com
3. Visiting our website and logging onto our online booking platform https://metrotownmassagetherapy.com/

I authorize Medical Services Plan to pay Metrotown Massage Therapy directly for all reimbursements for benefits payable to me under the Medical and Health Care Services Regulation for care provided to me at this clinic. I make this assignment in full knowledge of the amount that I will personally be responsible for and the amount that is reimbursable by the Medical Services Plan which will be directed to Metrotown Massage Therapy to be applied against any outstanding monies I owe for services provided.

By signing below, I consent to the above policies

Patient/Guardian signature *Date*

Please Indicate the Location of your Complaint



Schedule A – I acknowledge and confirm that the areas of my body circled on the above diagram will be touched by the RMT during the course of my treatments at the clinic. If there are any concerns, please bring it up in person with the RMT before treatment begins.

HEALTH QUESTIONNAIRE

Please list any medications you currently take, and if you have a history of any medical conditions:

Do you have a history of cardiovascular disease, or any other medical conditions?

Have you ever had any fractures? If yes, where and when?

Do you suffer from headaches?

Have you sought previous therapy for this complaint? (eg. Physiotherapy/Registered Massage Therapy/Chiropractic)

Please add any additional comments that would be relevant to your practitioner: