Patient Information

Massage Therapy

Tuxedo Physiotherapy
156-2025 Corydon Avenue
Winnipeg, Manitoba R3P 0N5
(204) 885-1109

Name: ______________________ ______________________ ______
Last First Initial

Date of Birth (dd/mm/yy): ____________________ Identifying Gender: ____________________

Address (#, Street Name): ____

City/Prov: ______________________________ Postal Code: ____________________

Cell Phone: (____) ____________________ Home Phone: (____) ____________________

Work Phone: (___) ______________ Ext: _____ Email Address: ______________________

Preferred method of contact:Phone ☐ Email ☐ Who referred you?____________________

Occupation: ____________________ Employer: ______________________________

Emergency Contact: ____________________Phone Number: (____) ____________________

Relationship to patient: ______________________

Consent for Assessment and Treatment
Before treatment begins, your therapist will develop and propose a personalized treatment plan based on your health history and initial assessment. The assessment may consist of various orthopedic tests depending on your condition.
You will be informed of what areas the proposed treatment will include, what clothing it is suggested that you remove (if any) and all anticipated outcomes of the treatment. You may alter or withdraw your consent at any time during the massage treatment.
A sheet and blanket will cover you at all times. With your consent, an area will be undraped, worked on and re-draped before continuing to the next area. At no time should you feel exposed.
You may experience temporary soreness 24-48 hours after a massage therapy treatment.
Your records may be stored either at a data storage facility digitally or on-site in a filing cabinet.
☐ I agree

Cancellation/No Show Policy
Your appointment time is reserved for you. We require 24 hours' notice for any cancellations. Patients who provide less than 24 hours' notice will be charged a $30 cancellation fee. Patients who do not cancel and do not show up for their appointment will be charged a $45 no show fee.
☐ I am aware of the Cancellation/No Show Policy

Consent for Communication/Release of Information
I authorize the clinic and its associated health professionals to communicate with my doctor, massage therapist, dentist, chiropractor, naturopathic doctor or others deemed as necessary for my beneficial treatment. I also understand that my personal and medical information is confidential and will only be disclosed to third parties with my permission.

☐ I agree

☐ I do not want my information shared with my other health care practitioners.

Email Communication

Effective July 1, 2014, Canada's new anti-spam legislation requires us to secure your consent so that we can communicate with you electronically.
We would like your permission to send you the following:

☐ Email reminders of upcoming appointments

☐ Instructions and videos regarding prescribed exercises and updates regarding the same.

☐ Notifications regarding upcoming classes/workshops/services.

Please complete this section if you have Massage Therapy coverage through Blue Cross:

Contract/Policy #: ______________________________

Name of subscriber (if not yourself): ____

Name of Patient: _________________________ Name of Guardian (if applicable): _______________________

Signature: ____ Date: ____________________________
Patient or Guardian

Medical Information:

Referring Doctor/Professional:____

Address: ______________________________________ Phone Number: (____) _________________________

Please list any major injuries or surgeries:

____

Please list current medications: ____

Have you taken any Advil or Tylenol in the last 48 hours? YES NO

Presence of: ☐ Pacemaker ☐ Artificial Joints ☐ Internal Wires/Pins

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Please describe your symptoms:

Sensation: ☐ sharp ☐ dull ☐ achy ☐ throbbing ☐ burning ☐ "numb" or pins and needles ☐ other

What is the intensity of this discomfort?

☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10

No pain ... Intolerable

This discomfort is affecting your:

☐ work ☐ activity/sports ☐ home life ☐ sleep

Health History	✓ current conditions	X experienced in the past

Muscle, Skeletal and Nervous Systems

- ☐ tension or migraine headaches
- ☐ whiplash/motor vehicle accident
- ☐ neck or shoulder pain or stiffness
- ☐ back or hip pain or stiffness
- ☐ upper extremity weakness or tingling
- ☐ lower extremity weakness or tingling
- ☐ head trauma or concussion
- ☐ loss of co-ordination or dizziness
- ☐ sleep or personality changes
- ☐ light-headedness/fatigue
- ☐ epilepsy/ seizures
- ☐ TMJ or tooth, jaw or ear pain
- ☐ vision or hearing loss or difficulty
- ☐ degenerating discs
- ☐ osteo or rheumatoid arthritis
- ☐ osteoporosis or bone disease
- ☐ spasm, strain or sprain
- ☐ tendonitis, fibrositis or bursitis
- ☐ fractures/pins, wire, plates
- ☐ carpal tunnel syndrome
- ☐ loss of sensation

Heart and Circulatory Systems

- ☐ blood pressure: high or low (circle which)
- ☐ chronic congestive heart failure
- ☐ heart disease/attack or stroke (CVA)
- ☐ chest pain or angina
- ☐ pacemaker or similar device
- ☐ varicose veins or phlebitis
- ☐ cold hands & feet or swelling
- ☐ diabetes
- ☐ poor healing/bruise easily

Skin and Immune System

- ☐ open sores, cuts or warts
- ☐ contagious skin disease
- ☐ tuberculosis or hepatitis
- ☐ HIV
- ☐ cancer
- ☐ allergies (food, environmental)

Digestive System

- ☐ nausea or vomiting
- ☐ constipation
- ☐ rapid weight loss
- ☐ appetite changes
- ☐ diarrhea
- ☐ bad taste in mouth
- ☐ irritable bowel
- ☐ ulcers
- ☐ gall bladder problems

Breathing System

- [ ] asthma
- [ ] bronchitis or emphysema
- [ ] shortness of breath
- [ ] frequent colds or sinus infections
- [ ] chronic cough/smoking

Genitourinary System

- [ ] painful urination
- [ ] unusual colour/odour
- [ ] hip or flank pain
- [ ] gynecological concerns
- [ ] pregnant currently