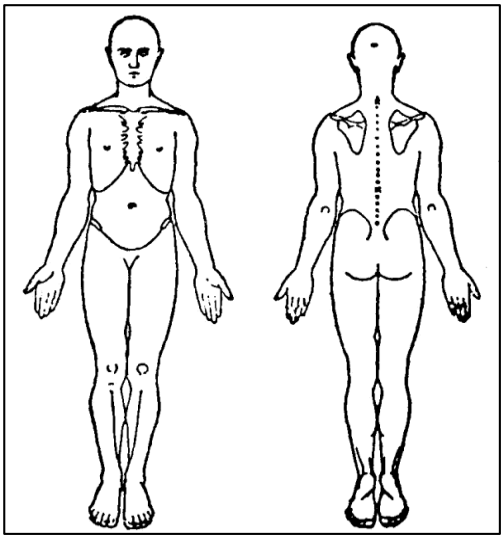
Patient Questionnaire Massage Therapy

Please fill out the questionnaire below to the best of your ability. If a question does not relate to you, leave it blank and the therapist will review it with you during your assessment.

NAME: _____ OCCUPATION: _____



Please show your symptoms on the diagram to the *left* (Sore/Stiff with an X, Tingling/Numbness with an O):

Is your injury interfering with your daily activities? ☐ Yes ☐ No

Please indicate below which goals you hope to address with treatment:

Reduce [☐ soreness ☐ swelling ☐ muscle spasm] ☐ Improve motion

☐ Return to sport/daily activity ☐ Return to work

How did your injury occur? _____

_____

_____

When did your symptoms occur? _____	**What type of massage are you interested in:** ☐ Therapeutic ☐ Relaxation ☐ Deep Tissue Other _____	
Describe your symptoms: ☐ Dull Ache ☐ Sharp ☐ Burning ☐ Throbbing ☐ Other _____	**Are your Symptoms:** ☐ Constant ☐ Intermittent	**Please rate your pain on a scale 0-10, 10 being worst pain imaginable.** Worst _____ Best _____ Currently _____
What aggravates your symptoms: ☐ Sitting ☐ Bending ☐ Lifting ☐ Standing ☐ Walking ☐ Other	**What eases your symptoms:** ☐ Hot Shower ☐ Lying down ☐ Medication ☐ Heat ☐ Ice	**Do you experience any:** ☐ Headaches ☐ Fainting ☐ Dizziness ☐ High Fever or Infection
Do your symptoms wake you up at night: ☐ Yes ☐ No	**Do you have any allergies to:** ☐ Lotions ☐ Nuts ☐ Detergents	**Do you have a:** ☐ Skin Condition ☐ Bruise easily

Have you had this problem before? ☐ Yes ☐ No _____	**Have you had any special test/procedures?** ☐ X-Ray ☐ MRI ☐ CT Scan ☐ Bone Scan ☐ Blood Test ☐ Ultrasound ☐ None ☐ Other _____
Are you taking any medication? ☐ Blood Thinners ☐ Anti-inflammatory ☐ Pain ☐ Muscle Relaxant ☐ Anti-depressant ☐ Steroids Others _____	**Have you seen any other health professional regarding this injury?** ☐ Doctor/Physician ☐ Surgeon/Specialist ☐ Physiotherapist ☐ Chiropractor ☐ Massage ☐ Other _____

Client Privacy Policy and Consent Form

The Panther Sports Medicine and Rehabilitation Centres are committed to controlling and protecting the collection, use and disclosure of the personal information provided by its patients. Our policy is guided by the Canadian Standards Association Model Code and synthesizes relevant material from the Protection of Personal Information Protection and Electronic Documents Act (PIPEDA), Personal Information Protection Act (PIPA), and Health Information Act (HIA). A complete copy of the Innovative Health Group Inc. Privacy Policy is available on the Panther Sports Medicine website at: www.PantherSportsMedicine.com.

I, _____, the patient/parent/guardian, herby agree to the following:

Authorization for Treatment – Consent for treatment at Panther Sports Medicine.

Release of Health Information – Authorize Panther Sports Medicine to provide medical information (status and progress) to my medical practitioner, insurance company, WCB, employer, Lawyer or their representative as needed for my treatment episode. I understand and authorize that this information may be exchanged electronically on my behalf.

Fees for Treatment – To pay outstanding fees incurred for therapy.

> **Benefits Assignment and Consent: I hereby assign benefits payable for my eligible claims to Panther Sports Medicine for submitting my claims electronically to my group benefits plan and I authorize the insurer to issue payment directly to Panther Sports Medicine. I understand the insurer is under no obligation to accept this assignment. I agree that this assignment will apply to all eligible claims submitted electronically by the provider. If I am a spouse I confirm that I am authorized by the plan member to assign benefit of payments to Panther Sports Medicine. In the event that claims are denied I understand that I remain responsible for payment to the provider for any services rendered and/or supplies provided.**

Patient Signature: _____ (signature of parent or legal guardian required if patient is less than 18 years old)

Date: _____

To reschedule an appointment, we require 24 hours notice. Otherwise, a late cancellation or no show fee may be charged. For your convenience, an answering machine will take your call after hours. Please contact the clinic you have booked an appointment with.