Health in Motion Rehabilitation Inc.

4256 Bathurst Street, suite 204
Tel: 416 – 250 – 1904
Fax: 416-250-8805
E– mail: healthinmotion@bellnet.ca

Client Contact Information Please complete all the responses to the best of your knowledge. (All information is strictly confidential)

Name (Last, First, MI)

Date of Birth (year/month/day) Sex

Address (Street, City, ST, Zip)

Home Phone Cell Phone

Marital statues (optional) Children/ How Many/ Age

Occupation (optional)

Emergency Contact Name Emergency Contact Phone

Physicians Name Physicians Contact Phone

E-mail address: _____

Please indicate what services HEALTH AND MOTION is providing;

Fee $

- Osteopathy ☐
- Kinesiology/Functional rehabilitation ☐
- Homeopathy ☐
- Speech pathology ☐
- Physio-therapy ☐
- Massage therapy ☐
- Nutritionist ☐
- Herbalist ☐

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Medical Information

Are you currently under a physician's care? ☐ Yes ☐ No

Are you taking any medication? ☐ Yes ☐ No

If so, please indicate what kind:

Do you have a tendency to bruise easily? ☐ Yes ☐ No

Have you recently had any vaccines or complications with vaccines? ☐ Yes ☐ No

Do you have any recent injuries? ☐ Yes ☐ No

Are you currently taking any blood pressure medication? ☐ Yes ☐ No

Are you currently taking any anti cholesterol medication? ☐ Yes ☐ No

If so, please explain:

Please check any of the following medical conditions/symptoms that you have experienced in the last year.

☐ Heart Disease	☐ Surgery	☐ Respiratory or Lung
☐ High Blood Pressure	☐ Arthritis	☐ Insomnia
☐ Hospitalization	☐ Asthma	☐ Diabetes
☐ Hepatitis	☐ Angina	☐ Migraines
☐ Carpel Tunnel	☐ Phlebitis/Thrombosis	☐ Kidney or Liver Disease
☐ Cancer or Tumors	☐ Fibromyalgia	☐ Pregnancy
☐ Stroke	☐ Disc Problems	☐ Repetitive Strain Injury
☐ Atherosclerosis	☐ Anemia	☐ Rapid Weight Loss
☐ Hemophilia	☐ Atherosclerosis	☐ Heart Murmur

Other: Please describe

Health in Motion Rehabilitation Inc.

Please read and sign

I verify that all information is correct and current to the best of my knowledge. I understand that any information provided is for safety purposes and will be kept strictly confidential, except that such information may be used by HEALTH IN MOTION for statistical analysis or scientific purposes.

I hereby give my consent to receive therapy and/or other bodywork or treatment (the "Services") from HEALTH IN MOTION and I acknowledge and agree that I am doing so at my own risk. My health and safety with respect to such Services are my sole responsibility. I acknowledge that my receipt of the Services from HEALTH IN MOTION may result in bodily injury to me. My decision to receive Services from HEALTH IN MOTION is voluntary, and I know of, understand and assume any and all the risks associated therewith.

In exchange for receiving Services from HEALTH IN MOTION, I, for myself and on behalf of my heirs, executors, administrators and personal representatives, hereby waive, release, discharge and hold harmless HEALTH IN MOTION its members, officers, employees and agents from any and all liability for any and all injuries, including death, damages or claims relating to or resulting from my receipt of the Services, now or in the future, foreseen or unforeseen. Further, I will indemnify and hold HEALTH IN MOTION, its members, officers, agents and employees, harmless from and against any and all claims, rights, damages, liabilities, losses, costs and expenses (including reasonable attorneys' fees) arising from or in connection with any injuries to other persons or damage to property caused by or attributed to me.

I acknowledge that I have read, and understand; the release and indemnification provisions set forth in the preceding paragraph, and agree to such terms.

Client Signature*

Date*

Therapy Client Waiver Form

Please take a moment to read and **initial** the following information:

I understand that therapy is provided for stress reduction, relaxation, relief from muscular tension, and improvement of circulation and energy flow. *

If I experience pain or discomfort during the session, I will immediately inform my therapist so that therapy can be adjusted to my level of comfort. I will not hold my therapist responsible for any pain or discomfort I experience during or after the session.*

I affirm that I have notified my therapist of all known medical conditions and injuries.*

I agree to inform the therapist of any changes in my health and medical condition. I understand that there shall be no liability on the therapist's part should I forget to do so.*

By signing this release, I hereby waive and release my therapist from any and all liability, past, present, and future relating to massage therapy and bodywork.*

I have read and agree to the policies therein.*

Client Name*

Client Signature*

Date*

Therapist Signature

Information and Suggestions

- Prior to therapy, please remove contact lenses and all jewelry. Pull long hair back with a clip or band.
- Feel free to ask your therapist any questions before, during, or after the session. Your therapist is a highly trained professional and will be happy to make you feel informed and comfortable.

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Consent to Disclosure, Transmittal or Examination of Clinical Records, Documents and Photos or Videos of Clinical Records, Documents and Photos or Videos held by Health in Motion Rehabilitation Inc.

I, _____

(print full name)

of SAME AS ON PATIENT'S INFORMATION FORM

(Address)

Hereby consent to the disclosure or transmittal to or the examination by: Insurers, Lawyers, Doctors and rehabilitation personnel.

I hereby waive any and all claims against Health in Motion Rehabilitation Inc., and its employees, contract therapists and staff in connection with the release and disclosure of the above described information.

_____ _____

(witness) Signature of patient and or guardian.

Note:

This authorization will remain in place unless rescinded or amended in writing at any time, except where action has been taken in reliance on the authorization.

Dated the_____ day of _____ , 200_____ .