

**Kevin G. Heath**  
**Registered Massage Therapist**

Client Full Name: \_\_\_\_\_ Date: \_\_\_\_\_

Phone (Home): \_\_\_\_\_ Business: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ Province: \_\_\_\_\_ Postal Code: \_\_\_\_\_

Birth Date: \_\_\_\_\_

Referred by Doctor? Yes  No  If yes, your Care Card No. is: \_\_\_\_\_

Doctor: \_\_\_\_\_ Referred to Clinic by: \_\_\_\_\_

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Are you presently on ICBC, WCB, or Disability Claim? Yes  No

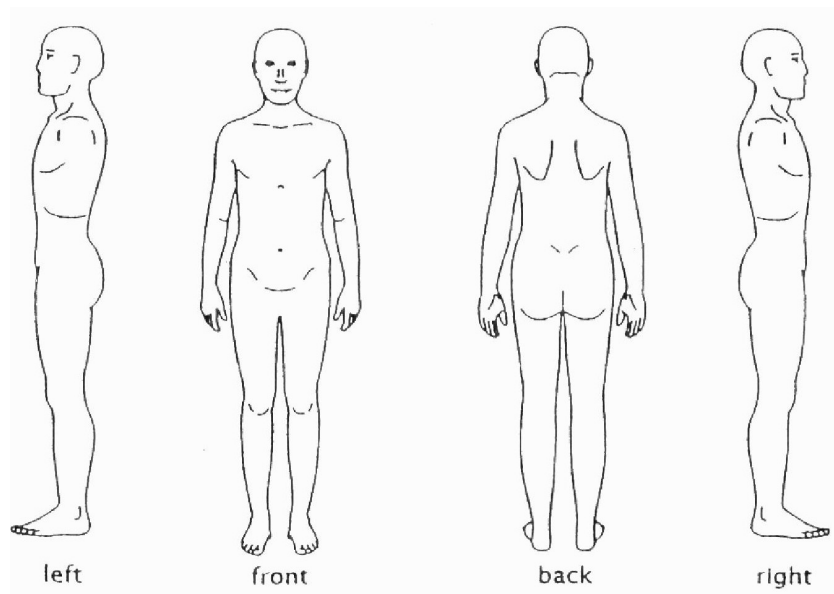
If yes, please see 'Information Regarding Claim' section, bottom of page 2.

Are you seeking therapeutic massage for stress/relaxation only  , or treatment of specific pain/discomfort

Please indicate on the following diagrams your area of concern and describe, below, the nature of your concern.

Please use the following symbols on the diagrams to indicate areas of:

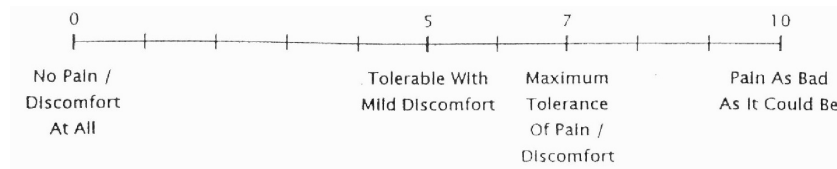
xxxx = Pain    /// = Stiffness    oooo = Numbness    \_\_\_\_\_ = Other Specify



The above complaint(s) are: Constant  On and Off

Is the above complaint(s) related to (check more than one if necessary): Posture   
Occupation  Motor Vehicle Accident  Injury  Diagnosed Condition

Make a mark (/) along the line at a point which represents your current level of pain/discomfort in your major areas of concern, somewhere between "No Pain/Discomfort At All" and "Pain As Bad As It Could Be".



Describe when you first noticed it including the date of onset: \_\_\_\_\_

\_\_\_\_\_

List past injuries/accidents/surgeries/diseases. (When) \_\_\_\_\_

\_\_\_\_\_

Do you frequently get headaches? (How often) \_\_\_\_\_

\_\_\_\_\_

List medications, supplements or other medical treatments you are currently taking.

\_\_\_\_\_

Do you have any allergies? \_\_\_\_\_

Current Occupation(s) \_\_\_\_\_

Previous occupation(s) if related to current concern(s): \_\_\_\_\_

In your opinion, how is your overall health (Psychological and physical) \_\_\_\_\_

\_\_\_\_\_

Do you have a major source of stress? (Physical or Psychological) \_\_\_\_\_

Do you exercise regularly? How often and what type? \_\_\_\_\_

Have you experienced a major change in your life in the past year? \_\_\_\_\_

Have you been treated by a Registered Massage Therapist before? \_\_\_\_\_

Have you been treated by a Physiotherapist/Chiropractor/Naturopathic doctor? \_\_\_\_\_

Kevin G. Heath is an opted out therapist and does not directly bill MSP, ICBC, WCB or private plans. Payment is required at the time of service. If you have extended medical coverage, your plan may reimburse part of the treatment fee.

*Initial Assessment and Treatment*      \$ 90.00

*One Hour Treatments*      \$ 90.00

*Subsequent Treatments (45 mins)*      \$ 75.00

*Subsequent Treatments (35 mins)*      \$ 50.00

**Your treatment time is reserved for you.**

**Please inform us 24 hours in advance** if you are unable to keep your appointment otherwise a charge will be rendered for missed appointments. I have read and agree with the above terms and conditions.

Name: \_\_\_\_\_

Signature: \_\_\_\_\_