Patient Information and Waiver

CONTACT INFORMATION

Name: _____ Date of Birth (d/m/y): _____

Address: _____

City: _____ Province: _____ Postal Code: _____

Home Phone: _____ Cell Phone: _____ Work Phone: _____

Occupation: _____

Dream Occupation: _____

Email: _____ Greenshield No.:_____

MEDICAL INFORMATION

Family Doctor: _____ Chiropractor: _____

Other health professional(s): _____

Do you currently have, or had in the past any issues related to any of the following (please specify):

- ☐ Heart attack
- ☐ Stroke
- ☐ Blood clots
- ☐ Heart disease
- ☐ High or low blood pressure
- ☐ Hemophilia
- ☐ Varicose veins
- ☐ Lymphedema
- ☐ Shortness of breath
- ☐ Bronchitis
- ☐ Emphysema
- ☐ Asthma
- ☐ Pain with cough / sneezing?
- ☐ Chronic cough
- ☐ Smoker?
- ☐ Cancer
- ☐ Diabetes
- ☐ Earache
- ☐ Hearing loss
- ☐ Vision loss
- ☐ Headaches:_____
- ☐ Dizziness
- ☐ Epilepsy
- ☐ Fibromyalgia
- ☐ Skin condition:_____
- ☐ Athlete's Foot
- ☐ Hepatitis
- ☐ Herpes
- ☐ HIV / AIDS
- ☐ Tuberculosis
- ☐ Arthritis:
- ☐ Bone / joint disease:
- ☐ Fractures:
- ☐ Sprains / Strains:
- ☐ Tendonitis:
- ☐ Bursitis:
- ☐ Jaw (TMJ) pain
- ☐ Menstrual pain
- ☐ Pregnant; due date:_____
- ☐ Sensitivity to heat / cold
- ☐ Other:

Any allergies? _____

Any motor vehicle accidents? When? _____

Any surgeries? When? _____

Any pins, plates, wires, or pacemakers? _____

Current medications: (include Homeopathy, natural remedies, etc.) _____

INJURY HISTORY

What is your primary complaint or major area of pain? _____

_____

How long have you had it? _____

Can you attribute it to anything? _____

What makes it worse? _____

What makes it better? _____

Does it interfere with your work?_____ Sleep? _____ Daily routine? _____

How much water do you drink? _____ How much tea/coffee do you consume? _____

Please sign the waiver on the back →

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TREATMENT AUTHORIZATION

Medical information in my patient file is **confidential** and will not be released to any outside sources without my written permission.

I authorize the staff at The POD to use my personal information for verification of direct billing with insurance companies (if applicable).

I give the staff at The POD permission to **communicate** information about my injury to:

- ☐ My family doctor and the above named healthcare practitioners.
- ☐ Any of the following: _____

  _____

I understand that I am receiving treatment from a **Certified Yoga Therapist** and/or **Registered Massage Therapist**, and am responsible for any treatment costs incurred.

I am responsible to ensure that my **private health insurance** covers the services provided.

I am aware that I may terminate any **massage** treatment at any point of the session at my discretion without reason.

I acknowledge that **yoga** is not a medical practice intended to cure any condition(s) I may have. I take responsibility for my well-being during all yoga classes and agree to hold the teacher harmless should I sustain an injury.

I am aware that **cancellations** with less than 12 hours notice are subject to the full appointment fee. Please give us 24 hours notice if you are unable to keep your appointment so that we may offer your time slot to another client.

I am aware that all returned cheques are subject to a $30 service fee.

The information provided on this form is complete to the best of my knowledge.

What is your preferred contact number? ☐ Home ☐Cell ☐Work

Signature: _____ Date: _____

Parental Signature if under 18: _____ Date: _____

How did you find out about The POD?_____