Vibrant Life Healthcare

6105 Patricia Bay Highway
Victoria, BC, V8Y 1T4

Patient Name ____________________ ____________________ ____________________
(As it appears on your carecard) **LAST** **FIRST** **MIDDLE**

What name would you prefer us to use? ________________________________

Address:______________________________ City:____________ Postal Code: _ _ _ - _ _ _

Date of Birth: ____________ ______ ________ Age: _______ Gender: _________
MONTH **DAY** **YEAR**

Weight (lbs): ________ Occupation: ____________________________________

Contact Information:

Home #: ________________________
Cell #: ________________________
Work #: ________________________

E-mail Address: ______________________________

What is your preferred method of appointment reminders?
□ Phone Call □ E-mail Reminder □ Text Reminder

Emergency Contact:

____________________ ____________________ ____________________
NAME **PHONE #** **RELATIONSHIP**

How did you hear about our office?
☐ Driving By ☐ Internet ☐ Friend (who?___________________________) ☐ Other

Are you on MSP Premium Assistance/Disability? YES □ NO □
Please note: There may be $23.00 coverage for Premium Assistance & Disability cases. The remaining portion is due on the date of service.

Were you injured at work? YES □ NO □
Do you have an active WCB claim? YES □ NO □
WCB claim#:____________________
* Please notify reception if you have not already if you have a WCB case

Is this an ICBC case? YES □ NO □
ICBC Claim #:____________________
* Please notify reception if you have not already if you have an ICBC case

____________________________ ____________________________
Date of Initial Consultation **Practitioner**

Please review the list of conditions and **check all that apply to you** (past or present). Be specific where necessary. All information is relevant in order to create a safe treatment plan for you.

Musculoskeletal:
- ☐ Headaches
- ☐ Joint pain
- ☐ Muscle weakness
- ☐ Muscle spasm/crar
- ☐ Muscle strain
- ☐ Ligament sprain
- ☐ Fracture
- ☐ Dislocation
- ☐ Tendonitis
- ☐ Bursitis
- ☐ Arthritis
- ☐ Osteoporosis
- ☐ Scoliosis
- ☐ Fibromyalgia
- ☐ Whiplash
- ☐ Other: ________________

Digestive
- ☐ Irritable Bowel Syndrome
- ☐ Crohn's Disease
- ☐ Colitis
- ☐ Diverticulosis
- ☐ Ulcers
- ☐ Heartburn/ Acid reflux
- ☐ Other:_________

Cardiovascular
- ☐ High blood pressure
- ☐ Low blood pressure
- ☐ Heart condition
- ☐ Pacemaker
- ☐ Stroke (CVA)
- ☐ Thrombosis (blood clot)
- ☐ Varicose veins/ Phlebitis
- ☐ Swelling
- ☐ Cold hands/feet
- ☐ Dizziness
- ☐ Poor circulation
- ☐ Clotting disorder
- ☐ Other: ________________

Respiratory:
- ☐ Asthma
- ☐ Shortness of breath
- ☐ Chronic cough
- ☐ Other: ________________

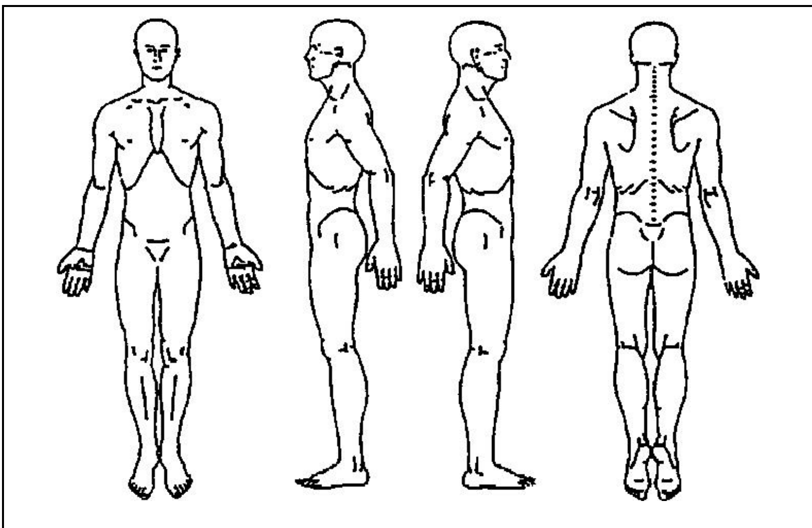
Family history of medical condition:
- ______________
- ______________

Nervous System:
- ☐ Numbness/tingling
- ☐ Neuropraxia (nerve compression)
- ☐ Paralysis
- ☐ Cerebral Palsy
- ☐ Seizure disorder
- ☐ Multiple Sclerosis
- ☐ Parkinson's Disease
- ☐ Spinal cord injury
- ☐ Head injury
- ☐ Herpes Zoster (Shingles)
- ☐ Other: ________________

Skin:
- ☐ Rash
- ☐ Athlete's foot
- ☐ Ringworm
- ☐ Acne
- ☐ Eczema
- ☐ Psoriasis
- ☐ Bruise easily
- ☐ Other: ________________

Women Only:
- ☐ Pregnancy- weeks:____
- ☐ Menstrual difficulties
- ☐ Ovarian/Uterine disorders
- ☐ Breast issues

Other:
- ☐ Cancer:________
- ☐ Diabetes- Type:________
- ☐ Thyroid disease
- ☐ Impaired vision
- ☐ Impaired hearing
- ☐ Depression
- ☐ Anxiety
- ☐ Fatigue
- ☐ Sleep difficulties
- ☐ Kidney disease
- ☐ Liver disease
- ☐ Hepatitis
- ☐ HIV
- ☐ Rods/Pins/Plates/ Shunts
- ☐ Implants:________
- ☐ Other: ___________________



Please indicate on the diagram the nature of your symptoms, using the symbols indicated:

Aching: OOO

Stabbing: XXX

Shooting/Referral: → → →

Numbness/tingling: **~~~**

Who is your family doctor?_____________________ Last Visit?_____________________

For what purpose? ____

Are you presently undergoing treatment for any condition? YES □ NO □ If so, what?

____

Please list **all major accidents, injuries or surgeries** you've had with approximate date of occurrence:

____

Please list **all medications** you are currently taking and what they are prescribed for:

____

Please list any NON-prescription vitamins, minerals, or other supplements you are currently taking:

____

Please list **all known allergies:**

____

Have you received a therapeutic massage from a Registered Massage Therapist before? YES □ NO □
Have you received treatment from a Chiropractor before? YES □ NO □

LIFESTYLE ASSESSMENT

NUTRITION

Do you eat 4 servings each of fruits and vegetables daily? YES □ NO □
How much water do you drink daily?____________________
How often do you eat fast food(eg. Fries, burgers, pop, pizza etc.)?_______________

How much alcohol do you drink per week? wine;_____ beer;_____ hard liquor;_____
Do you smoke cigarettes?______ How many packs/week?_____ For how many years?_____
Do you have a history of substance abuse or alcohol abuse? YES □ NO □

EXERCISE

Briefly describe your exercise level (type of activity, frequency, intensity and duration):
____

How many hours on average, do you sit daily? _________

Psychosocial

Rate the level of stress in your work life: Low___ Moderate___ High___ Severe___
Rate the level of stress in your personal life: Low___ Moderate___ High___ Severe___
Do you have daily stress reduction strategies? YES □ NO □
How many hours do you sleep on an average night? ________________
Sleeping Position? Back___ Stomach___ Right Side___ Left Side___ Both Sides_____
How many pillows? _________   Do you feel rested when you wake? ________________

Please tell us what you want out of your experience here — what are your goals?

____

____

Office Policies

Payment for examination and treatments are due on the day services are rendered. Your treatments or custom foot orthotics may be covered, or partially covered by ICBC, WCB, MSP or your Insurance Provider. If, for whatever reason, your coverage is denied, then *you are fully responsible for payment of all services rendered.*

- **Please allow us at least 24 hours notice if you are unable to keep your appointment.**
- **If you miss/no-show your appointment, you will be charged the full appointment fee.**

Because many people have allergies to perfumes and other scents, we ask that you refrain from wearing them while in our office.

I understand and agree to the above policies.

__________________________________ __________________________________

Print Name Signature of Patient

Date: ____________________________

Please check

□ I, hereby, give consent to share my health history information among the Vibrant Life Healthcare professionals (within their respective scopes of practice) for the purpose of efficient use of clinical resources for the achievement of integrated healthcare for the intended purpose of interprofessional collaboration by all health providers for the overall benefit of my health.

Assignment of Benefits

Some insurance plans allow for direct billing. Please provide the following information so we can bill your plan directly, if applicable to you and keep your information on file.

CARECARD #: ____

INSURANCE COMPANY NAME: ____

PLAN MEMBER NAME: ____

POLICY/GROUP NUMBER: ____

PLAN MEMBER ID #: ____

If you have dual insurance through a spouse or family member, please provide the following:

INSURANCE COMPANY NAME: ____

PLAN MEMBER NAME: ____

PLAN MEMBER DATE OF BIRTH: ____

POLICY/GROUP NUMBER: ____

PLAN MEMBER ID #: ____

I understand that the fees listed in this claim and/or future claims may not be covered by or may exceed my plan benefits. I understand that I am financially responsible to the service provider for the entire cost associated with this claim and/or future claims.

I hereby assign my benefits payable from this claim and/or future claims to Vibrant Life Healthcare and authorize payment directly to them. Vibrant Life Healthcare may bill electronically or manually on my behalf.

I understand that my insurance provider and/or a benefit plan sponsor including; MSP Premium Assistance, reserve the right to modify assignment privileges for specific benefits, benefit categories, specific service providers or service provider categories.

I hereby certify that the information provided in connection with this claim is true, accurate and complete. I hereby authorize any licensed physician, medical practitioner, hospital, pharmacy, clinic or other medically related facility, pre-payment organization, insurance company, third party administrator, plan sponsor, employer, government agency, investigative or security agency or any other person or organization having any records, knowledge or information concerning this claim or my health or the health of any insured member of my family as it may relate to this claim to release such information to my insurance provider and to exchange such information with any of the named parties where such exchange is necessary for the proper adjudication and processing of the claim. A photocopy of this signed authorization shall be as valid as the original.

Plan Member's Signature: __________________________________ Date: _______________

The Exchange of Personal Information

Personal information that we collect and disclose about you, and if applicable, your spouse and/or dependents, is used by the insurer and/or plan administrator and their service provider(s) for the purposes of assessing your claims, underwriting, investigating, auditing, and administering the group benefits plan, including the investigation of fraud and/or plan abuse.

Authorization and Consent

I authorize Vibrant Life Healthcare to collect, use, and disclose personal information concerning any claims submitted on my behalf with the insurer and/or plan administrator and their service provider(s) for the above purposes.
I authorize the insurer and/or plan administrator and their service provider(s) to:

- Use my personal information for the above purposes.
- Exchange personal information with any individual or organization, including healthcare professionals, investigative agencies, insurers and reinsurers, and administrators of government benefits or other benefits programs when relevant for the above purposes.
- Exchange personal information concerning any claims submitted with the plan member or a person acting on behalf of the plan member.
- Exchange personal information for the above purposes electronically or in any other manner.

I understand that personal information may be subject to disclosure to those authorized under applicable law.

I agree that a photocopy or electronic version of this authorization shall be as valid as the original, and may remain in effect for the continued administration of the group benefits plan.

Plan Member's Signature: ________________________________ Date: _______________

Registered Massage Therapy

Confidentiality Agreement and Informed Consent to Treatment

Registered Massage Therapists are health care professionals committed to restoring and maintaining optimal health and pain-free function of the body. They are educated and trained to accurately assess and treat with techniques that include massage and manual therapy, joint mobilization, hydrotherapy, and rehabilitative exercise such as stretching, strengthening, postural exercise and patient education. Prior to receiving treatment, patient should understand the following:

- I understand that it is important to keep my Massage Therapist up to date on any changes to my health, if I am on any medication or over the counter drugs, if I am pregnant or suspect I may be pregnant.
- I understand that a record will be kept of the health services provided to me. This record will be kept confidential and will not be released to others unless so directed by myself or unless law requires it.
- I understand that my identity will be protected at all times.
- I understand that I may look at my medical record at any time and can request a copy of it by paying the appropriate fee.
- I understand that the results are not guaranteed. I do not expect the Massage Therapist will be able to anticipate and explain all risks and complications.
- I understand that I am free to withdraw my consent and to discontinue participation in these procedures at any time.

With this knowledge, I voluntarily consent to the therapeutic procedures mentioned above and I intend for this consent form to cover the entire course of treatment with this Massage Therapist.

Patient Name: (Please Print) ____

Name of guardian if patient is a child: ____

Signature of Patient (Or Guardian): ____

Date (mm/dd/yyyy): ________/_________/______________