Best of Health, Inc.

Senior's Massage Therapy

Client Name:_____ Birthdate:_____

Center/Residence:_____ Room #: _____

Address:_____

City:_____ Province:_____ Postal Code: _____

Phone Number:_____ Email: _____

Family Contact:_____ Relationship:_____

Phone Number:_____ Email: _____

Billing Information: ☐ *Check if billing address is same as above*

Attention:_____

Address: _____

City:_____ Province:_____ Postal Code: _____

Massage Therapy Waiver:

By signing this form, I indicate a willingness to accept any result of the treatment conducted or recommended by this therapist, without holding the clinic or therapist liable for any circumstance, condition, or aggravation of, the treatment may influence or cause. This treatment does not in any way replace medical treatment where necessary.

Cancellation Policy:

Please note that 24 hours' notice is required to re-schedule or cancel appointments. Cancellations with less than 24 hours' notice, or missed appointments, are subject to a $50 cancellation fee. To reschedule or cancel an appointment, please call 587.775.1514.

Late Payment Fees:

We offer monthly billing as a convenience for our clients; payment is due upon receipt of the invoice. Please note that any unpaid invoices more than 60 days overdue will be assessed a $25 late payment penalty each month.

Client Name: _____

Client/POA Signature: _____

Date: _____

Best of Health, Inc.

Credit Card Authorization Form

Cardholder Name: _____

Billing Address: _____

City:_____Province:_____Postal Code: _____

Phone Number:_____Email: _____

Card Type ☐ Mastercard ☐ Visa

Card Number: _____

Expiry Date:_____CVV : _____

Credit Card Authorization

I authorize Best of Health, Inc. to charge my credit card above as required for payment on the account of -

Client Name(s) : _____

_____

I understand that my information will be saved to file for future transactions on the account.

I understand that this authorization will remain in effect until cancelled.

Cardholder Signature: _____

Date: _____

To cancel this authorization, or update your payment information, please call 587.775.1514

1134 Coopers Drive SW, Airdrie AB T4B 0Z8
Phone (587)775-1514 Email admin@bohm.ca
www.BOHM.ca

Best of Health, Inc. - Confidential Client Medical History

This history is strictly confidential and will not be released to anyone without your prior written consent. The information gathered will help determine the appropriate type of procedures to be included in your treatment plan.

NAME:_____ DATE: _____

Please indicate which conditions you currently suffer from or have suffered from in the past:

- ☐ Anxiety
- ☐ PTSD
- ☐ ADHD
- ☐ Seizures
- ☐ Autism
- ☐ Insomnia
- ☐ Stroke
- ☐ Epilepsy
- ☐ Depression
- ☐ Panic Attacks
- ☐ Atrial Fibrillation
- ☐ Cerebral Palsy
- ☐ Fibromyalgia
- ☐ Adrenal Fatigue
- ☐ Heart Attack
- ☐ Chronic Fatigue Syndrome
- ☐ High Blood Pressure
- ☐ Low Blood Pressure
- ☐ Scoliosis/Lordosis/Kyphosis
- ☐ Stressed/Overwhelmed
- ☐ Heart Disease *List type:* _____
- ☐ Cancer *List Location(s):* _____

- ☐ Varicose Veins
- ☐ Sciatica
- ☐ Diabetes
- ☐ Ulcers
- ☐ Endometriosis
- ☐ Hamstring Pain
- ☐ Knee Pain
- ☐ Ankle Pain
- ☐ Heel Pain
- ☐ Plantar Fasciitis
- ☐ Prostate Problems
- ☐ Hemorrhoids
- ☐ Drop Foot
- ☐ Constipation
- ☐ Chronic Diarrhea
- ☐ Slipped/Herniated/Bulging Disc
- ☐ Degenerative Disc Disease
- ☐ Abnormal Gait (walk)
- ☐ Incontinence/Bladder Issues
- ☐ Gynecological Problems

- ☐ Dementia
- ☐ Alzheimer's
- ☐ Confusion
- ☐ Mucus Cough
- ☐ Vertigo
- ☐ Sinus Issues
- ☐ Tennis Elbow
- ☐ Carpal Tunnel
- ☐ Stiff Neck
- ☐ Dizziness
- ☐ Earaches
- ☐ TMJ/ Jaw Pain
- ☐ Low Back Pain
- ☐ Whiplash
- ☐ Migraines
- ☐ Frequent Colds
- ☐ Dry/Runny/Itchy Eyes
- ☐ Impaired Vision
- ☐ Kinked Neck
- ☐ Sternal Pain
- ☐ Difficulty Swallowing Food
- ☐ Frozen Shoulder or Injury
- ☐ Grind/Clench Teeth
- ☐ Tension Headaches
- ☐ Rib Pain or Injury
- ☐ Concussion *Date(s):* _____
- ☐ Tailbone Pain or Injury

- ☐ Skin Allergies
- ☐ Emphysema
- ☐ Diverticulitis
- ☐ Edema
- ☐ Asthma
- ☐ Allergies
- ☐ Indigestion
- ☐ Heartburn
- ☐ Gas
- ☐ Bloating
- ☐ Colitis
- ☐ IBS
- ☐ Respiratory Issues
- ☐ Crohn's Disease
- ☐ Multiple Sclerosis

- ☐ Osteoporosis
- ☐ Neuropathy
- ☐ Lupus
- ☐ Parkinson's Disease
- ☐ Muscular Dystrophy
- ☐ Rheumatoid or Osteo Arthritis

For any of the following that are applicable, please list location(s) and/or type:

- ☐ Implants _____
- ☐ Fusions _____
- ☐ Sprains _____
- ☐ Broken Bones _____
- ☐ Contagious Conditions _____
- ☐ Tendinitis _____
- ☐ Blood Clots _____
- ☐ Limited Range of Motion _____

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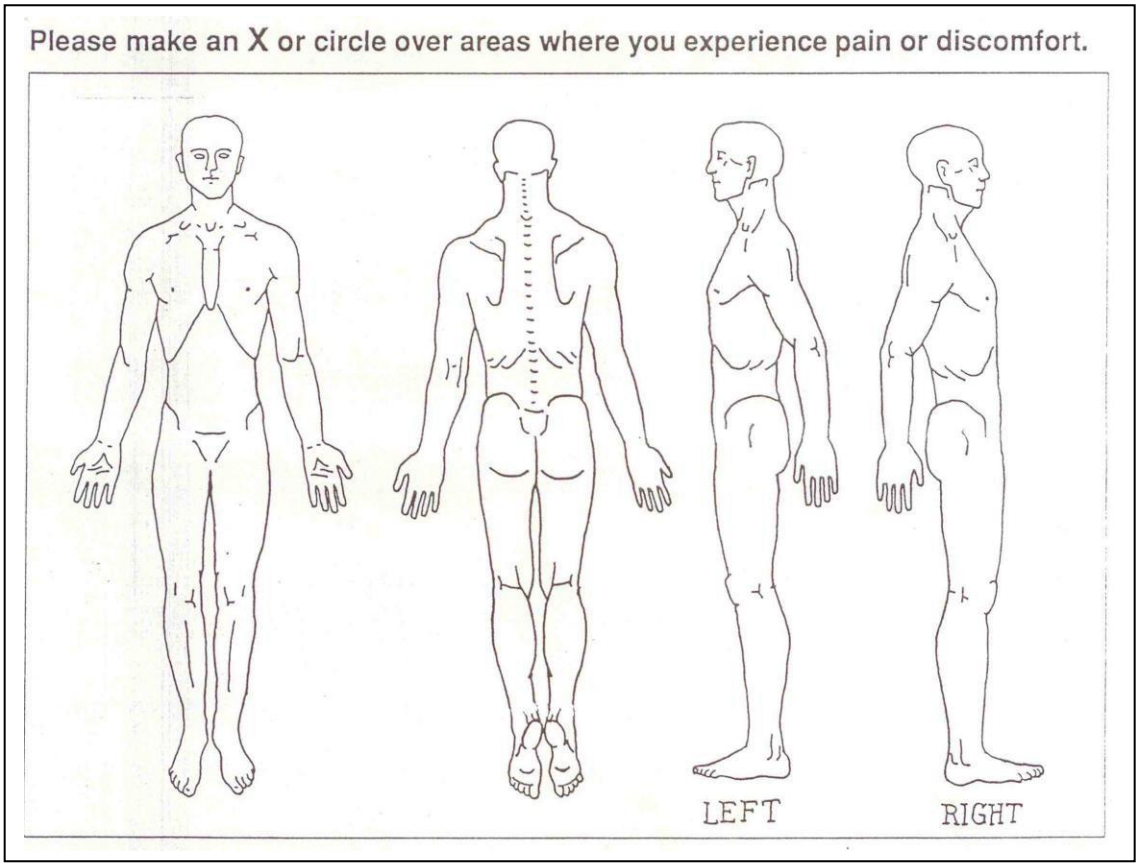

Please list any other relevant conditions or concerns:

_____

_____

_____

_____

_____

_____

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