Best of Health Inc.

Client Information Bowen/Massage Therapy Waiver

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: __________________

Invoice delivery preference: ☐ Canada Post ☐ Email

Preferred Payment Method: ☐ Monthly Cheque ☐ Credit Card on File

Treatment 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 thereof 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. If less than 24 hours' notice is given, or an appointment is missed, a **$50 fee** will be applied. To change an appointment, please call 587.775.1514 or use the online booking calendar at www.bohm.ca

Client Name: ____

Client/POA Signature: ____________________________________

Date: ____

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
- ☐ Jaw Pain
- ☐ TMJ
- ☐ 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 _______________________________

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

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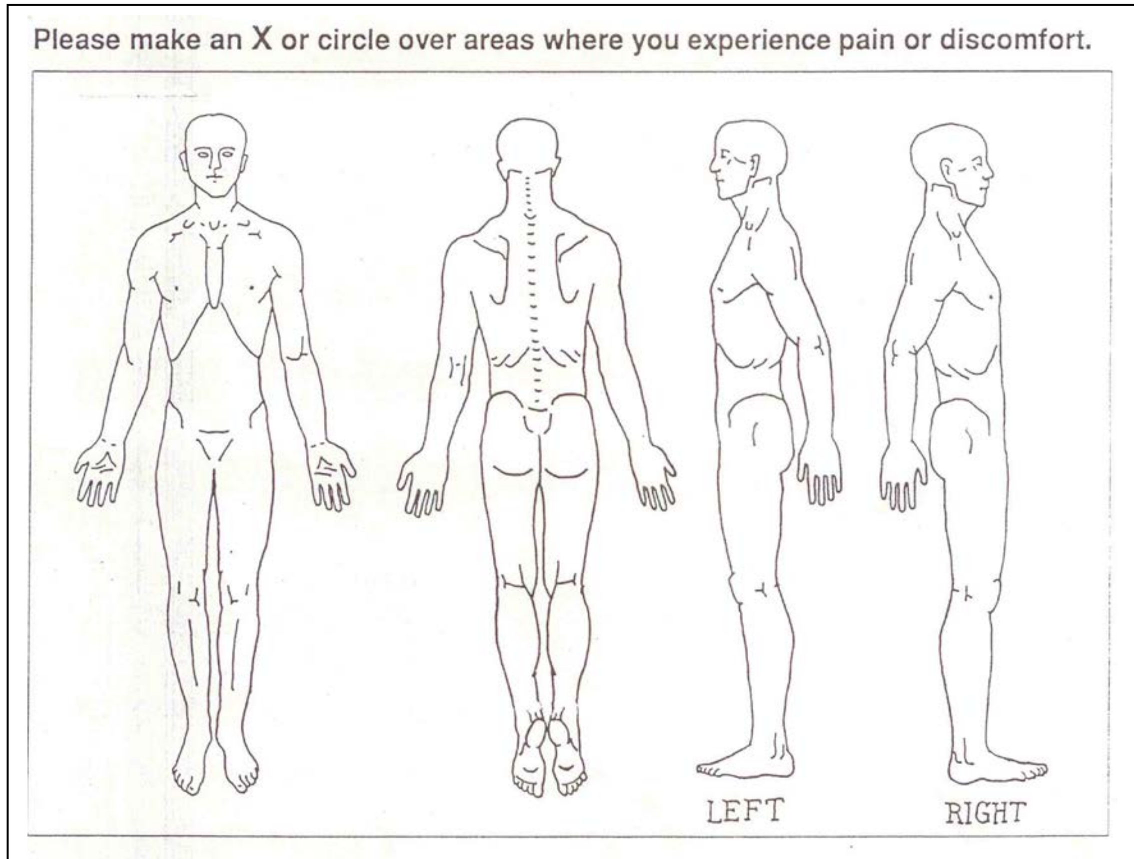
NAME: ____ DATE: ______________________



Please list any other relevant conditions or concerns:

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Best of Health, Inc.

Massage Therapy & Bowen Technique

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

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