



#101-15399 102A Avenue  
Surrey, B.C. V3R 7K1  
Tel: (604) 951-8959

**Personal information:**

Name: \_\_\_\_\_ Gender: \_\_\_\_\_  
Address: \_\_\_\_\_ City: \_\_\_\_\_ Province: \_\_\_\_\_ Postal code: \_\_\_\_\_  
Birth date: month \_\_\_\_\_ day \_\_\_\_\_ year \_\_\_\_\_ Age: \_\_\_\_\_ Height: \_\_\_\_\_ Weight: \_\_\_\_\_  
Home phone: \_\_\_\_\_ Alternate phone: \_\_\_\_\_  
Email address: \_\_\_\_\_ Email Reminder  No  Yes  
Emergency contact name : \_\_\_\_\_ Emergency contact phone: \_\_\_\_\_

**Medical doctor:**

Name of medical doctor: \_\_\_\_\_ Phone number: \_\_\_\_\_  
Location: \_\_\_\_\_

**Employment information:**

Occupation: \_\_\_\_\_ Employer: \_\_\_\_\_  
Employer Address: \_\_\_\_\_ Phone: \_\_\_\_\_

**Medical insurance:**

Personal Health No/Care Card.: \_\_\_\_\_  
Do you have extended health care that covers Massage Therapy?  No  Yes.

**How did you know about this clinic?**

- |  |                                       |
|--|---------------------------------------|
| <input type="checkbox"/> Friend or Patient from this office (name) _____ | <input type="checkbox"/> Yellow Pages |
| <input type="checkbox"/> Other health care professional (name) _____     | <input type="checkbox"/> Sign         |
| <input type="checkbox"/> Other (specify) _____                           | <input type="checkbox"/> Web Site     |

**Personal health information:**

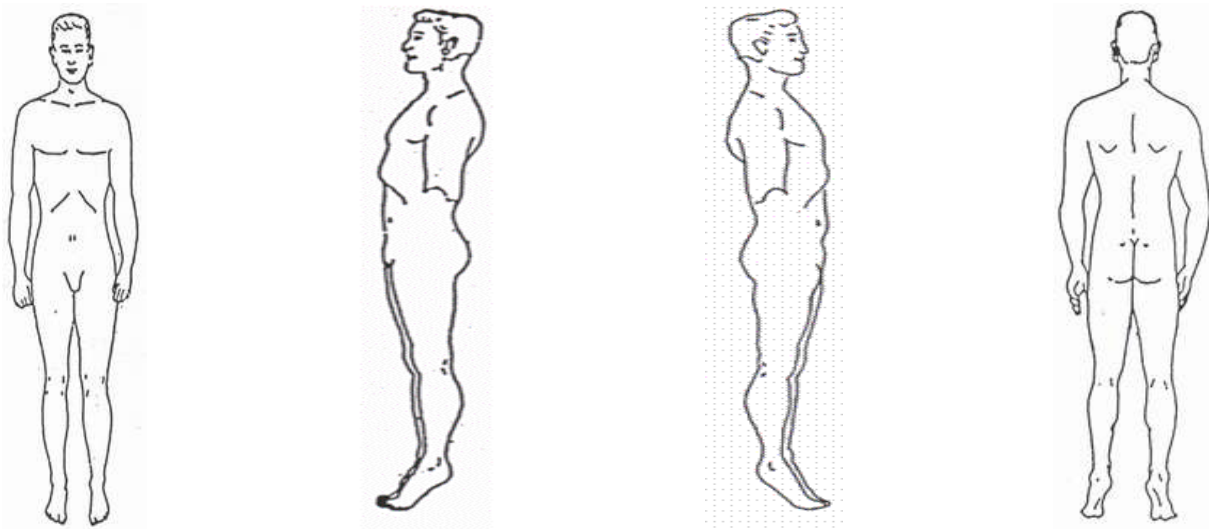
Women only: Is it possible that you may be pregnant?  No  Yes. The expected due date is: \_\_\_\_\_  
Please list all previous illnesses, surgeries, accidents, injuries allergies and other significant health conditions:  
\_\_\_\_\_  
\_\_\_\_\_

Have you ever been diagnosed with Hepatitis?  No  Yes.  
Have you ever been tested for HIV?  No.  Yes. Test date: \_\_\_\_\_ Test result:  Positive  Negative.

Are you presently on any medication?  No  Yes. Please list: \_\_\_\_\_

Have you received Massage Therapy before?  No  Yes. Date of last visit: \_\_\_\_\_  
Do you have an open ICBC/WCB claim?  No  Yes

- Reason for visit (major complaint): \_\_\_\_\_
- How did your symptoms occur? \_\_\_\_\_
- When did your symptoms start? \_\_\_\_\_
- Please indicate (circle) on the diagram below the area(s) in which you are experiencing problems:



**Fee**      \$75.00    half hour massage therapy  
               \$135.00   one hour massage therapy

**Schedule:** (\*Subject to change without notice)

**48 hours notice is required for cancellation or rescheduling of an appointment. I understand that if such notice is not given, I will be billed for the FULL FEE\* of the missed visit.**

**Extended Health Care Insurance** plans will often cover massage therapy. Please check your plan to determine your coverage. If you are eligible for coverage, it is the **patient's responsibility to submit their receipt of service to their health insurance provider for reimbursement.**

I, the undersigned, also understand that Navpreet Muker-Lehal,RMT and Jag Grewal, RMT are independent and separate practices from Impulse Health And Wellness.

Please be advised that your treatment time, will/may consist of an evaluation, hands on massage, hydrotherapy, stretching and/or rehab. (As seen necessary by your Registered Massage Therapist.)  
 If you are late for your scheduled appointment, you will receive treatment for only the remaining time of your appointment.

**Patient's Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_  
 (or signature of guardian or spouse authorizing care)

# Impulse Health And Wellness

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## Agreement of Service

Navpreet Muker-Lehal, R.M.T.  
Jag Grewal, R.M.T

I, the undersigned, understand that a limited number of massage treatments are covered by the B.C. Medical Plan and that services rendered in this office are the responsibility of myself, should Medical Service Plan fail to pay for all or part of the amount due.

Extended Health Care Insurance often covers massage therapy. Please check your plan to determine your coverage. If you are eligible for coverage, it is the **patient's responsibility to submit their receipt of service to their health insurance provider for reimbursement.**

**48 hours notice is required for cancellation or rescheduling of any appointment. I understand that if such notice is not given, I will be billed for the FULL FEE of the appointment.** \_\_\_\_\_ Patient's Initial

**Outstanding fees will be sent to collections. Administrative fees of \$25.00. will be applied to the balance owing.** \_\_\_\_\_ Patient's Initial

If you are late for your scheduled appointment, you will receive treatment for only the remaining time of your appointment.

I also understand that the email for my scheduled appointments are a courtesy, and may or may not be provided during the course of my treatment.

Please be advised that your treatment time will/may consist of an evaluation, hands on massage, hydrotherapy, stretching and/or rehab. (As seen necessary by your Registered Massage Therapist.)

I understand that Navpreet Muker-Lehal, RMT and Jag Grewal, RMT are independent and a separate practice from Impulse Health And Wellness.

Patient's Signature: \_\_\_\_\_  
(Or signature of guardian or spouse authorizing care)

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

# **INFORMED CONSENT TO MASSAGE THERAPY AND CARE**

I hereby request and consent to the performance of massage treatments and other procedures, including various modes of physical therapy on me by the massage therapist named below and/or anyone working in this clinic authorized by the massage therapist named below.

I have had an opportunity to discuss with the massage therapist named below and/or other office or clinic personnel, the nature and purpose of massage treatments and other procedures. I understand that the results are not guaranteed.

I further understand and am informed that, as in all health care, in the practice of massage therapy there may be some slight risk(s) to treatments. I do not expect the therapist to be able to anticipate and explain all the risks and complications and I wish to rely on the therapist to exercise judgment during the course of the procedure which the therapist feels at the time, based upon the facts then known, and is in my best interests.

I have read the above consent. I have also had an opportunity to ask questions about its content, and by signing below I agree to the above mentioned massage therapy procedures. I intend this consent form to cover the entire course of treatment for my present and future conditions.

I understand that my Massage Therapy Session will include the following (as deemed necessary by your RMT) : Evaluation, Hands on (time determined by the therapist), stretching/Rehab/Patient Education, Proper sanitization/disinfecting protocol.

I understand that while the therapist is following all of the health and safety guidelines outlined by the Registered Massage Therapist Association of BC, the College of massage Therapists of BC and the Provincial Health Officer, there are no guarantees that I may not come into contact with Covid 19.

## **TO BE COMPLETED BY PATIENT:**

\_\_\_\_\_  
**PRINT PATIENT NAME**

\_\_\_\_\_  
**SIGNATURE OF PATIENT  
(or parent/guardian)**

\_\_\_\_\_  
**DATE SIGNED**

**\*FOR OFFICE USE ONLY\***

**Navpreet Muker-Lehal, RMT  
Jag Grewal, RMT**