CONFIDENTIAL CLIENT INFORMATION AND CONSENT FORM

FYI: an accurate health history ensures that it is safe for you to receive a massage treatment, and helps the therapist determine a proper treatment plan. When your health status changes in the future, please let us know. All information gathered on this form is confidential. Your written authorization is legally required before any of this information can be released.

Name: _____

Address: _____

_____Postal Code _____

Today's date: _____Date of Birth: _____

Height: _____ Weight: _____

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

Email Address: _____

Occupation: _____

How did you hear about us? _____

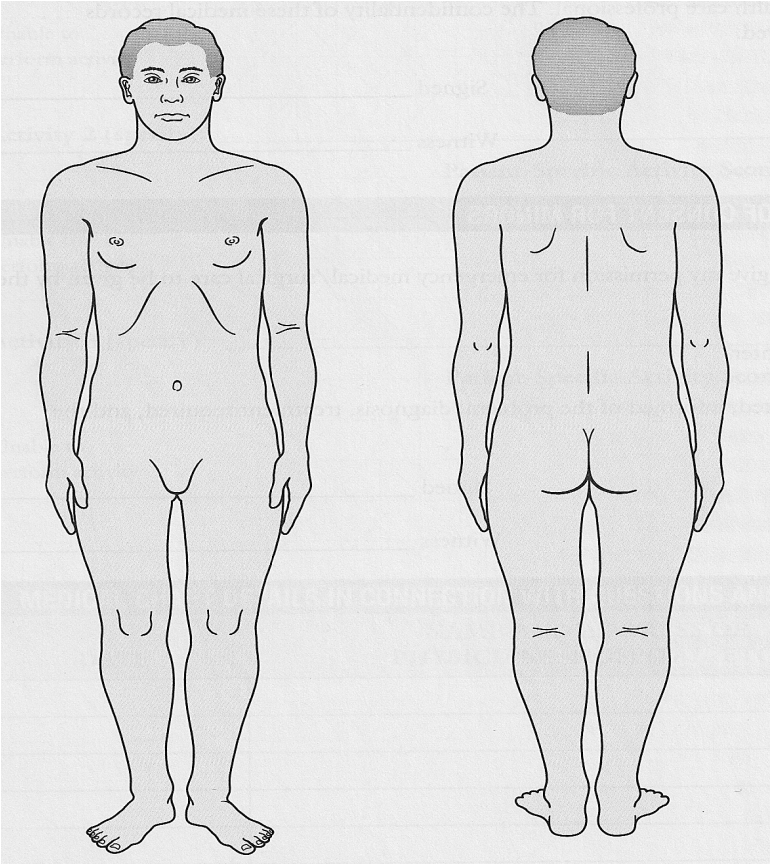
Physician's name/Phone number & address (if you know it) _____

_____

What is your major area of concern that you would like treated? (Write below & circle the areas)

_____

_____



On the body diagrams to the left, please circle the areas that you are experiencing problems/pain/stiffness etc. If you are experiencing pain in one area and feeling it elsewhere, please indicate this with arrows.

(Please flip page over)

Please indicate all conditions you have experienced. Mark **C** for current or **P** for past.

Joint/Soft Tissue Discomfort:

_____ Arms
_____ Upper Back
_____ Mid Back
_____ Lower Back
_____ Degenerative Discs
_____ Feet
_____ Hands (Wrists)
_____ Hips
_____ Jaw (TMJ)
_____ Knees (L or R)
_____ Ankles (L or R)
_____ Legs
_____ Neck
_____ Osteo Arthritis
_____ Rheumatoid Arthritis
_____ Limitation of Movement
_____ Shoulders
In which joints: _____
Other _____

Cardiovascular:

_____ High Blood Pressure
_____ Low Blood Pressure
_____ Coronary Heart Disease
_____ Heart Attack
_____ Stroke / CVA
_____ Pacemaker
_____ Heart Murmur
_____ Palpitations
_____ Varicose Veins
_____ Swelling of the Ankles
_____ Poor Circulation
_____Diabetes (Type 1 or 2)

Eye, Ear, Nose, Throat:

_____ Frequent Colds
_____ Glasses or Contacts
_____ Hearing Loss
_____ Sinus Infection
_____ Swollen Glands

Skin:

_____ Rashes
_____ Itching
_____ Bruise Easily
_____ Dryness
_____ Boils
Other _____

General Symptoms:

_____ Fainting
_____ Dizziness
_____ Loss of Sleep
_____ Fatigue
_____ Nervousness
_____ Sudden Weight Loss/Gain
_____ Numbness
_____ Paralysis
_____ Headaches (Tension)
_____ Migraines

Infectious:

_____ Hepatitis
_____ Tuberculosis
_____ Human Immunodeficiency Virus (HIV)
_____ Herpes
_____ Cold
_____ Athlete's Foot
_____ Warts
Other _____

Digestive:

_____ Poor Appetite
_____ Belching/Gas
_____ Constipation
_____ Diarrhea
_____ Allergies
_____ Ulcer
_____ Vomiting
_____ Chrohns/Colitis/IBD etc.
_____ Nausea
_____ Diabetes (Type 1 or 2)

Respiratory:

_____ Chronic Cough
_____ Bronchitis
_____ Asthma
_____ Hay Fever
_____ Difficulty Breathing
_____ Smoking
_____ Emphysema
_____ Pneumonia

For Women:

Reproductive:

_____ Pregnant
Due date _____
_____ Painful Menstruation
_____ Heavy Flow
_____ Irregular Cycle
_____ Menopausal
_____ Pre-menopausal
_____ Post-menopausal
_____ Birth control
type _____
_____ Number of children

Lifestyle Questions

Regular eating habits Yes No
Do you take vitamins: Yes No **Do you take prescribed medications:** Yes No
Frequency: _____
Type: _____
_____
_____

Regular exercise Yes No
Type: _____ Frequency: _____

High Stress Yes No IF YES: At home At work Both

Have you received care from any of the following: (circle)

physiotherapist chiropractor massage therapist

naturopath other:

Have you had surgery in the past? If yes, for what?

Have you had any fractures/sprains in the past? If yes, where?

Have you had any serious illnesses in the past? If yes, what?

Did the current injury result from a motor vehicle accident or workplace injury? Yes No

Please read carefully, and sign.

I attest that the information I have provided is true and complete to the best of my knowledge.

I understand the information I have provided on this form is confidential and will not be released without my written consent.

I consent to therapeutic massage treatment by the above named massage therapist.

I also understand that I am responsible for any charges incurred in the course of my treatment.

PRINT NAME: _____ SIGNATURE: _____

DATE: _____

INFORMED CONSENT TO MASSAGE THERAPY TREATMENT

I understand that the massage therapist is providing massage therapy services within their scope of practice as defined by both the Massage Therapist Association of Alberta and the Massage Therapist Association of Saskatchewan, Inc.

I hereby consent for my therapist to treat me with massage therapy for the above noted purposes including such assessments, examinations and techniques, which may be recommended, by my therapist.

I acknowledge that the therapist is not a physician and does not diagnose illness, disease, or any other physical or mental disorder. I clearly understand that massage therapy is not a substitute for a medical examination. It is recommended that I attend my personal physician for any ailments that I may be experiencing. I acknowledge that no assurance or guarantee has been provided to me as to the results of the treatment. I acknowledge that with any treatment, there can be risks and those risks have been explained to me and I assume those risks.

I acknowledge and understand that the therapist must be fully aware of my existing medical conditions. I have completed my medical history form as provided by my therapist and disclosed to the therapist all of those medical conditions affecting me. It is my responsibility to keep the massage therapist updated on my medical history. The information I have provided is true and complete to the best of my knowledge.

I authorize my therapist to release or obtain information pertaining to my condition(s) and/or treatment to/from my other caregivers or third party payers, only when necessary and only with a prior verbal request.

I have read the above noted consent and I have had the opportunity to question the contents and my therapy. By signing this form, I confirm my consent to treatment and intend this consent to cover the treatment discussed with me and such additional treatment as proposed by my therapist from time to time, to deal with my physical condition and for which I have sought treatment. I understand that at any time, I may withdraw my consent and treatment will be stopped.

Patient Name _____

Signature of Patient/Guardian _____

Date Signed _____