ASSESSMENT FIRST REMEDIAL MASSAGE THERAPY
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: _____ Work: _____ Cell: _____

Email Address: _____

Health Insurance Company _____

Health Insurance Plan _____ ID # _____

Occupation: _____

How did you hear about us? _____

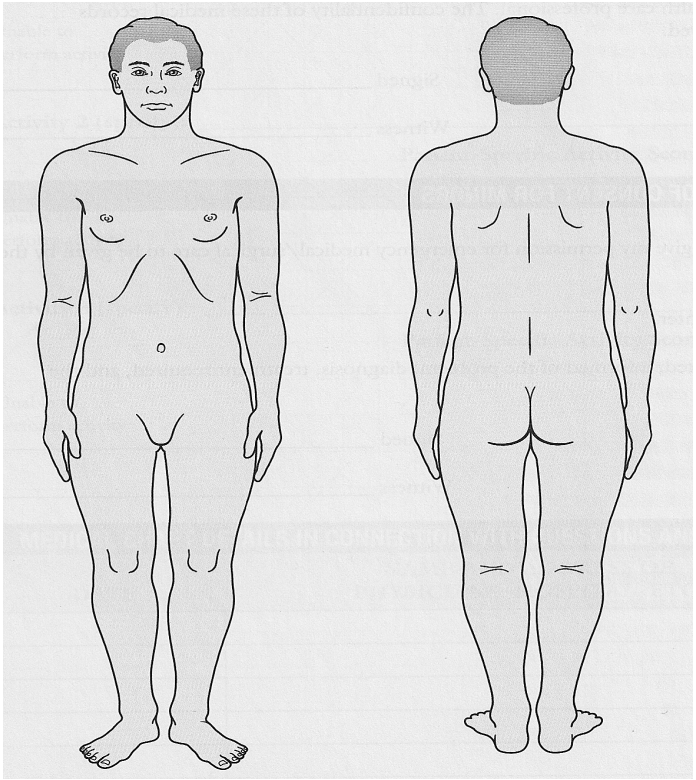
Physician's name/Phone number & address (if you know it) _____

_____

IF YOU HAVE CANCER, OR IF YOU HAVE EVER BEEN TREATED FOR IT, PLEASE ADVISE BEFORE TREATMENT BEGINS.

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 pages over

1. **General Signs and Symptoms** (check Yes and add comments if you have any of the following):

	Yes	Comments
A. Are there any areas you **protect**?		
B. Any **pain** or **tenderness**?		
C. Any **numbness** or **reduced sensation**?		
D. Any areas that are **warm or red**?		
E. Any **swelling** or **tendency** to swell?		
F. Fatigue		

2. **Specific Medical Conditions** (please include dates):

	Yes	Comments
A. **Skin conditions**		
B. A**llergies or sensitivities** (if you use any special lotion, feel free to bring it)		
C. **Cancer** (please describe the type of cancer and location)		
D. **Liver or kidney conditions**		
E. **Respiratory or lung condition**s (such as emphysema or asthma)		
F. **Cardiovascular conditions** (history of heart condition, high blood pressure, angina, stroke, **varicose veins**, **blood clots**)		
G. **Diabetes** (describe the type, any complications, whether blood sugar is well-controlled)		
H. **Bone or joint problems** (such as osteoporosis, arthritis or bone metastasis)		
I. **Digestive problems** (such as colitis, IBS, constipation, or diarrhea)		
J. **Injuries** (such as, accidents, tendonitis, fractures)		

K. **Autoimmune** (such as lupus, chronic fatigue syndrome, or fibromyalgia)		
L. **Hematological conditions** (such as anemia, low white blood count, low platelets)		
M. **Other**		

3. **Surgical Procedures** (please include dates):

a. Please list surgeries or surgical procedures. If lymph nodes were tested as part of the process, please describe the area(s) from which they were removed.

4. **Medications, including chemotherapies** (past and present chemos if possible). Please list the reason for the medication:

Drug	Reason for taking	Side effects you are experiencing from the drug

5. **List other medical treatments,** such as radiation or physical therapy (please include dates):

_____

_____

_____

_____

_____

_____

6. **Do you have any <u>POSITIONING</u> needs due to** (check box):

☐ incision	☐ swelling	☐ medical device	☐ difficulty breathing
☐ discomfort	☐ tumor sites	☐ nausea	☐ other

Please describe:

_____

_____

_____

_____

LIFESTYLE QUESTIONS:

1) Do you smoke tobacco/cigars/pipes/other? How much? _____

When did you have your last smoke? _____

2) Do you drink alcohol? How much? _____When did you have your last drink? _____

3) Do you get regular exercise? Yes No

Type _____

Frequency _____

4) Do you have regular eating habits? Yes No When did you last eat? _____

5) Do you take vitamins/supplements? Yes No What type? _____

_____

6) Is your life high stress? Yes No If yes, at home? At work? Both?

Please read carefully, and sign.

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

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 (Please print) _____

Signature _____

If 16 or younger – Your signature _____

Signature of your parent or guardian _____Date _____

And FINALLY, to please the federal government and it's anti-spam law….

Do you agree to email communication from Assessment First Remedial Massage Therapy and/or Marie Trafford, RMT, CLT

Yes _____ No _____

Would you prefer occasional text messages?

Yes _____ No _____