ASSESSMENT FIRST REMEDIAL MASSAGE THERAPY – MARIE TRAFFORD, RMT/CLT

FYI: an accurate health history ensures that it 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 # _____

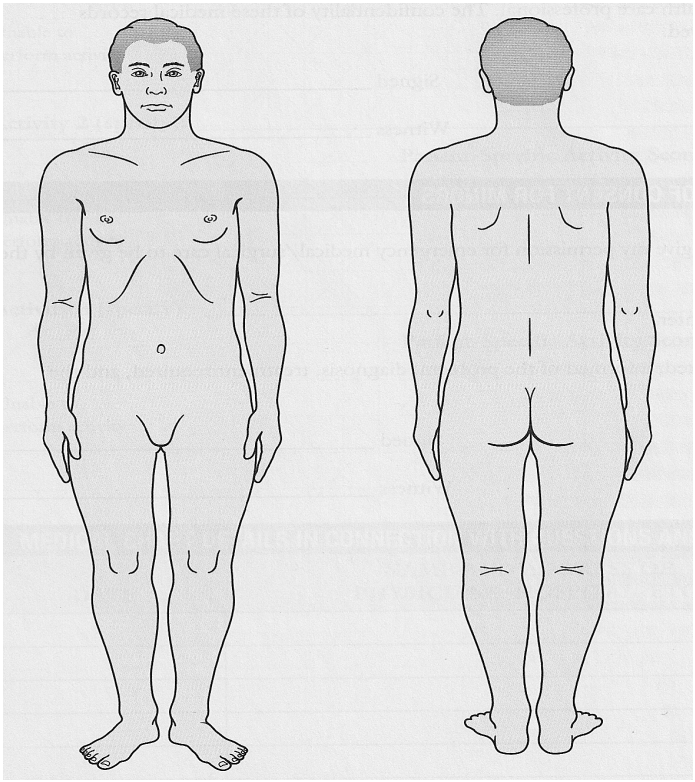
Occupation: _____

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 where 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

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

A. Are there any areas of your body that you **protect?** _____Yes _____No

Comments:

_____

_____

_____

B. Any **pain** or **tenderness?** _____ Yes _____ No

Comments:

_____

_____

_____

C. Any **numbness** or **reduced sensation**? _____ Yes _____ No

Comments:

_____

_____

D. Any areas that are **warm** or **red?** _____Yes _____No

Comments:

_____

_____

E. Any **swelling** or **tendency** to swell? _____ Yes _____ No

Comments:

_____

_____

_____

F. Fatigue? _____ Yes _____ No

Comments:

_____

_____

_____

2. Specific Medical Conditions (please include dates in the comment section):

A. **Skin conditions?**
Comments:

_____

_____

_____

B. **Allergies or sensitivities?** (If you use any special lotion, feel free to bring it with you)
Comments:

_____

_____

_____

C. **Cancer?** (Please describe the type of cancer and location and the dates)
Comments:

_____

_____

_____

D. **Liver or kidney conditions?**
Comments:

_____

_____

_____

E. **Respiratory or lung conditions** (such as emphysema or asthma or COPD)
Comments:

_____

_____

_____

F. **Cardiovascular conditions** (history of heart condition, high blood pressure (controlled? how?), angina, stroke, varicose veins, **<u>blood clots</u>**)
Comments:

_____

_____

_____

G. **Diabetes** (describe the type, any complications, whether blood sugar is well-controlled – how?)
Comments:

_____

H. **Bone or joint problems** (such as scoliosis, osteoporosis, joint replacements, broken bones (which ones), arthritis or bone metastasis)
Comments:

I. **Digestive problems** (such as colitis, IBS, constipation, or diarrhea)
Comments:

J. **Injuries** (such as, accidents, tendonitis, fractures, whiplash)
Comments:

K. **Autoimmune** (such as lupus, psoriasis, chronic fatigue syndrome, or fibromyalgia)
Comments:

L. **Hematological conditions** (such as anemia, low white blood count, low platelets)
Comments:

M. Other
Comments:

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

Please list surgeries, or surgical procedures. (Year, if possible) If lymph nodes were tested as part of the process, please describe the area(s) from which the nodes were removed and, if possible, how many were removed.

Comments:

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):

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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:

_____

_____

7. LIFESTYLE QUESTIONS:

A. Do you smoke tobacco/cigars/pipes/other? How much? _____

When did you have your last smoke? _____

B. Do you drink alcohol? How much? _____When did you have your last drink? _____

C. Do you get regular exercise? Yes_____ No _____

Type _____

Frequency _____

D. Do you have regular eating habits? Yes_____ No_____ When did you last eat? _____

E. How do you sleep? On your side _____ Stomach _____ Back _____ Do you sleep well? Yes/No?

F. How many children do you have? _____ Natural or C-Section deliveries? Yes _____ No _____

G. Do you take vitamins/supplements? Yes _____No _____ If yes, what type? (Please list)

_____

_____

_____

7) Is your life high stress? Yes_____ No _____ If yes, at home? At work? Both?

8) Are you left or right-handed? _____

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: _____

ASSESSMENT FIRST REMEDIAL MASSAGE THERAPY

INFORMED CONSENT TO MASSAGE THERAPY TREATMENT

I understand the massage therapist is providing massage therapy services within her scope of practice, as defined by 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 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 I attend my personal physician for any ailments I may be experiencing. I acknowledge 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 the therapist must be fully aware of my existing medical conditions. I have completed my medical history form 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) _____

Patient Signature _____

If 16, or younger, the (printed) name and signature of your parent, or guardian

_____ Date: _____

And FINALLY, to please the federal government of Canada and its anti-spam law:

Do you agree to email communication form Marie Trafford and Assessment First Remedial Massage Therapy?

Yes _____ No _____

Would you prefer the communication be done by text message?

Yes _____ No _____