CONFIDENTIAL CLIENT INFORMATION AND CONSENT FORM
PLEASE PRINT

Today's Date: _____

Name: _____ Birth Date: _____

Address: _____

_____Postal Code _____

Email address: _____

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

Insurance Provider: _____ Contract/Plan # _____ Grp #/ID #_____

Occupation:_____

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

_____

Reason Treatment Requested: _____

Sports Played/Physical Activity: _____

Height _____ Weight _____

Stress Level: at home (high low) at work (high low) in general (high low)

Timing & nature of injuries/accidents: _____

_____

Timing & nature of surgical procedures: _____

_____

Are you a cancer survivor? _____

Do you have any orthopedic implements? Where? _____

How do you sleep? Side _____ Back_____ Stomach _____

Referring Physician/Physiotherapist/Chiropractor, etc.: _____

_____

Referral attached: Yes No Date of referral _____

Are you currently receiving treatment by any other health care professionals? _____

_____

Current medications/vitamins/minerals and conditions used for: _____

Cardiovascular insufficiency:

_____ High blood pressure
_____ Low blood pressure
_____ Chronic congestive heart failure
_____ Heart disease
_____ History of myocardial infarction
_____ Phlebitis
_____ Stroke
_____ Presence of pacemaker or similar device
_____ Cholesterol Problems
_____ Diabetes (1 or 2) ____ Insulin use
_____ Other

Comments:
_____
_____
_____
_____
_____
_____
_____
_____
_____

Respirator insufficiency:

_____ Chronic cough
_____ Bronchitis
_____ Shortness of breath
_____ Allergies
_____ Asthma/Emphysema
_____ Sinus Issues/Infections

Comments: _____
_____
_____
_____
_____
_____

Stomach/Digestive tract disorders:

_____ Irritable bowel syndrome/disorder (IBS or IBD)
_____ Crohn's Disease
_____ Colitis
_____ Other

Comments: _____
_____
_____
_____

Other Conditions:

_____ Headaches (migraine/tension)
_____ Fainting/Dizziness
_____ Cancer (current or remission)
_____ Edema
_____ Hepatitis
_____ Pregnant
_____ TMJ (Temporal Mandibular Joint)
_____ Skin conditions
_____ Do you smoke?

Comments: _____
_____ Arthritis
_____ Epilepsy
_____ Tuberculosis
_____ HIV/Aids
_____ Hernia
_____Osteoporosis
_____ MS
_____ Side/stomach/back sleeper?

Do you have any other health/soft tissue conditions that are not addressed on this form?

_____

_____

_____

_____

Soft Tissue/Joints:

Location and nature of soft tissue and joint dysfunction(s): _____

_____

_____

Pain:

Aggravating factors: _____

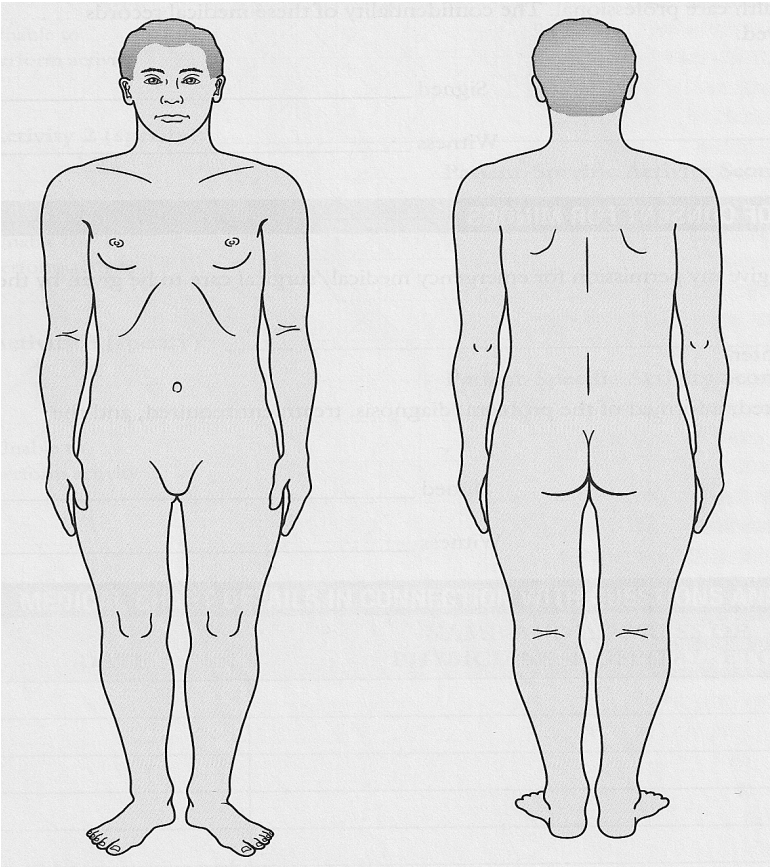
What makes it better? _____

Frequency/Occurrence: _____

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 soft tissue problems/pain/stiffness etc. If you are experiencing pain in one area and feeling it elsewhere, please indicate this with arrows.

All patient information is confidential and subject to the Personal Health Information Act and will not be released without signed consent by the patient.
Please read carefully and sign.

I, _____, do hereby grant Marie Trafford, RMT/CLT permission to provide massage therapy treatment to me as discussed. I understand I may refuse, alter, or rescind consent at any time.

I understand the charges of the above mentioned treatment may not be covered by, or may exceed, my policy benefits. I understand I am financially responsible for the full cost of treatment.

Signature: _____

The information on this form is true to the best of my knowledge.
Signed: _____ Dated: _____

Assessment First at Radiance Massage Therapy periodically emails clinic information updates to clients. We also have the ability to text you reminders to your cell phone. Please indicate yes or no to provide us legal authorization to occasionally email or text you.
Yes No Email address: _____
Cell phone number: _____

How did you hear about us? _____
We have a referral discount, so please provide your friend/relative's name.

CANCELLATION POLICY:

We understand life happens and sometimes you just can't make it to a scheduled appointment, consequently, the therapist always has discretion to void this policy. If 24-hours notice is not given prior to your appointment, then the full fee of the treatment applies. This outstanding balance will have to be paid before booking your next appointment.

I have read the above and understand:

Signed: _____ Dated: _____