

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: _____

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

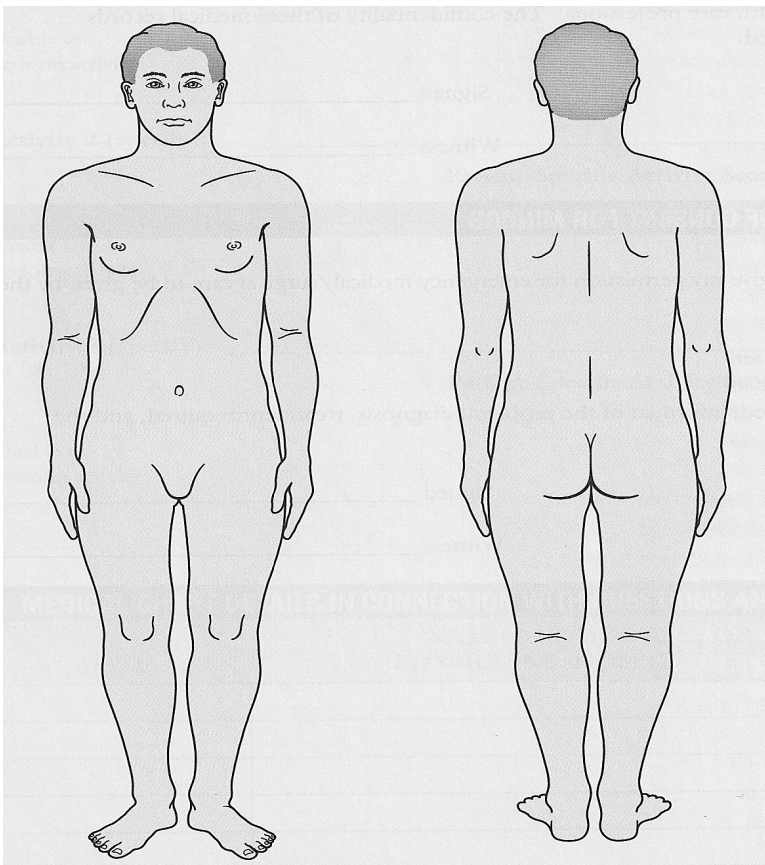
Email Address: _____

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.

ASSESSMENT FIRST REMEDIAL MASSAGE THERAPY - Marie Trafford, RMT

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
 - _____ Hips
 - _____ Jaw
 - _____ Knees

 - _____ 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

Eye, Ear, Nose, Throat:

- _____ Allergies
- _____ 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
- _____ Nausea
- _____ Ulcer
- _____ Vomiting

- _____ 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 _____