Christopher Shperuk, RMT 701 Memorial Ave., Unit 3 Thunder Bay, ON P7B3Z7 (807)343-7932

FOR OFFICE USE ONLY

Updated

1._____
2._____
3._____
4._____
5._____

Consent to treatment

Client's Name _____ Date:_____

It has been explained to me what an informed consent is, and;

- ◊ *An accurate health history is important to ensure that it is safe for you to receive a massage treatment. If your health status changes in the future, please let me know. All information gathered for this treatment is confidential, except as required or allowed by law, or to facilitate diagnosis (assessment) or treatment. You will be asked to provide written authorization for release of any information.*
- ◊ ***I understand that there is a 24-hour cancellation notice, otherwise the full treatment fee is charged.***
- ◊ *It has been explained to me, the specific areas to be massaged/treated, or those specific areas to be omitted.*
- ◊ *I understand the risks and benefits of the massage/treatment, and have been consulted by the R.M.T. Furthermore, I may as questions at any given time during my massage/treatment, and may alter or refuse further treatment.*
- ◊ *I have fully disclosed all medical conditions that I am aware of, and understand that is will be my responsibility to update my treatment file of any changes in my health status.*
- ◊ *I acknowledge that this information is confidential, and that no personal data shall be released to anyone.*

Client's Signature _____ Date:_____

Name: _____ Date of Birth:_____

Address: _____ City:_____ Postal Code:_____

Home Phone: _____ Cell Phone:_____ Email:_____

Occupation_____ Business Phone:_____

Emergency Contact:_____ Phone Number:_____ Relationship: _____

Doctor:_____ Address: _____

What brings you for massage(primary complaint):_____

Who referred you?_____

Are you currently under a physican's care ☐ Yes ☐ No If yes, why?_____

Are you currently taking any medications? ☐ Yes ☐ No

If yes, please list _____

Please list any known allergies (medications, foods, scents, etc)_____

Identify any secondary health care providers (chiropractors, physiotherapists, nutritionist, etc.)

_____

_____

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Have you ever received a professional massage? ☐ Yes ☐ No If yes, date of last treatment?_____

Surgeries - Date: _____ Injuries – Date:_____

_____ _____

_____ _____

_____ _____

Current Health Condition

Respiratory
- ☐ Chronic Cough
- ☐ Shortness of breath
- ☐ Asthma
- ☐ Bronchitis
- ☐ Emphysema
- ☐ Family history of the above

Skin Conditions
- ☐ Psoriasis
- ☐ Eczema
- ☐ Athlete's foot
- ☐ Warts
- ☐ Rashes
- ☐ Sensitive Skin
- ☐ Bruise easily
- ☐ Other_____

Uro-genital
- ☐ Kidney disease
- ☐ Bladder conditions
- ☐ Pregnant
- ☐ P.M.S.
- ☐ Other_____

Endrocrine
- ☐ Thyroid
- ☐ Diabetes
- ☐ Other_____

Musculo Sketetal
- ☐ Muscular discomfort
- ☐ Joint discomfort
- ☐ Fractured/broken bones
- ☐ Osteoarthritis
- ☐ Rheumatoid Arthritis
- ☐ Fibromyalgia
- ☐ Family history of the above

Gastro-Intestinal
- ☐ Constipation(Chronic)
- ☐ Diarrhea(Chronic)
- ☐ Diverticulitis
- ☐ Crohn's
- ☐ Ulcers
- ☐ Family history of the above

Infectious Conditions
- ☐ Sexually transmitted disease
- ☐ H.I.V./A.I.D.S.
- ☐ Hepatitis
- ☐ Tuberculosis
- ☐ Other_____

Other
- ☐ Depression
- ☐ Eating Disorder
- ☐ Drug/alcohol addiction
- ☐ Cancer/tumors
- ☐ Claustrophobia

Circulatory
- ☐ Low blood Pressure
- ☐ High blood Pressure
- ☐ Edema/swelling
- ☐ Varicose Veins
- ☐ Heart Disease
- ☐ Blood clot
- ☐ Phlebitis
- ☐ Stroke
- ☐ Heart attack
- ☐ Angina
- ☐ Hemophilia
- ☐ Poor circulation
- ☐ Raynaud's
- ☐ Family history of the above

Neurological
- ☐ Dizziness
- ☐ Multiple sclerosis
- ☐ Epilepsy
- ☐ Paralysis
- ☐ Numbness/tingling
- ☐ Headaches
- ☐ Hearing impairment
- ☐ Visual impairment

PERSONAL HEALTH BEHAVIORS

Sleep(hours per night _____
List exercise and hobbies(include frequency) _____
Eating habits: Number of meals per day_____
Quality of meals ☐ poor ☐ satisfactory ☐ good
Dietary restrictions; _____
Please list any vitamins/herbal supplements you are currently taking:_____
_____
Alcohol consumption: How Much? _____ How Often? _____
Smoking habits: Average cigarettes per day _____Length of habit _____

Special Needs

☐ Contact Lenses	☐ Mobility Device	☐ Wires	☐ Steel Rods
☐ Glasses	☐ Pace Maker	☐ Internal Pins	☐ Artificial Joints
☐ Hearing Aid	☐ Brace	☐ Dentures	☐ Artificial Limbs

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