

FOR
OFFICE
USE ONLY

Consent to treatment

Client's Name _____ Date: _____

Updated

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

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 ask 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 it 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 physician'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.)

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 _____

Endocrine

- 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

- | | | | |
|---|--|--|--|
| <input type="checkbox"/> Contact Lenses | <input type="checkbox"/> Mobility Device | <input type="checkbox"/> Wires | <input type="checkbox"/> Steel Rods |
| <input type="checkbox"/> Glasses | <input type="checkbox"/> Pace Maker | <input type="checkbox"/> Internal Pins | <input type="checkbox"/> Artificial Joints |
| <input type="checkbox"/> Hearing Aid | <input type="checkbox"/> Brace | <input type="checkbox"/> Dentures | <input type="checkbox"/> Artificial Limbs |

This information is used in cooperation with the client to promote sage and effective massage therapy treatments. If any concerns arise, please do not hesitate to inquire about them. All information provided by the client is respected and is strictly confidential.