double sided

CONFIDENTIAL INFORMATION

Welcome. I want to make your appointment as pleasant and comfortable as possible.
If at any time you have questions regarding your visit, please let me know.

(Please print)

Name: ______________________ Phone: (H) ______________ (W) ______________

Street: ______________________ City: __________ State: __________ Zip: ______________

Date of Birth: ______________________ Age: _____ ☐ Male / ☐ Female

Email Address: ______________________ Referred by: ______________________

HAVE YOU EVER RECEIVED MASSAGE THERAPY? ☐ Yes / ☐ No If yes, what type of massage have you experienced?

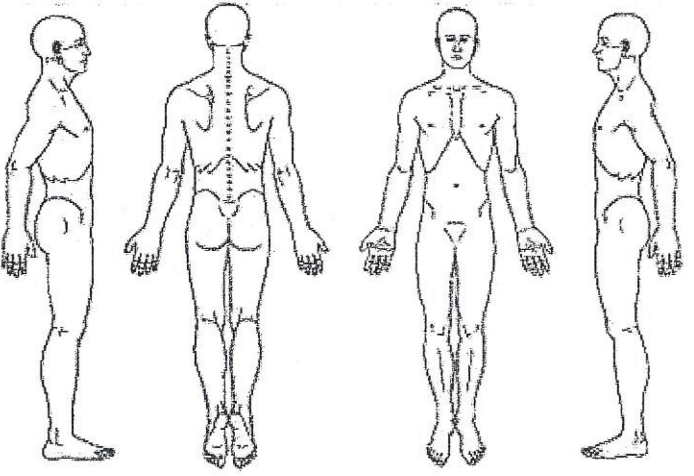
____

ARE YOU PREGNANT? ☐ Yes / ☐ No **HOW MANY WEEKS?** ______________________

DO YOU HAVE ANY OF THE FOLLOWING TODAY?

☐ Anxiety ☐ High/Low BP
☐ Inflammation ☐ Jaw/Ear Pain
☐ Severe Pain ☐ Dizziness
☐ Headache ☐ Varicose Veins

↓ Shade in any area(s) you feel discomfort ↓



DO YOU HAVE A PRESSURE PREFERENCE?

☐ Light
☐ Heavy
☐ Deep

HOW MUCH WATER DO YOU DRINK PER DAY?

☐ Two – Four glasses
☐ Five – Seven glasses
☐ Eight or more glasses

WHAT ARE YOUR GOALS FOR MAINTENANCE?

☐ Relaxation
☐ Injury Rehabilitation
☐ High Activity Level, Maintenance Massage
☐ Other ______________________

ARE YOU UNDER MEDICAL CARE FOR ANY OF THE FOLLOWING? (circle all pertaining)

heart
varicose veins
neck injury
high/low blood pressure
phlebitis/circulatory problems
back injury
rheumatoid arthritis
kidney disease

asthma/respiratory
pelvic inflammatory disease
whiplash
fainting or dizziness
headaches or migraine
jaw or ear pain
osteoarthritis
skin conditions

fibromyalgia
epilepsy
osteoporosis
cancer
diabetes
Crohn's disease
nervous disorders
other: ______________

HAVE YOU HAD ANY SURGERIES IN THE PAST? If yes, for what? ______________________

____

HAVE YOU HAD ANY SERIOUS ILLNESS IN THE PAST? If yes, what/when? ______________________

____

ANY SPRAINS OR FRACTURES? ______________________

ARE THERE ANY OTHER HEALTH CONDITIONS I SHOULD BE AWARE OF? □ Yes / □ No

If yes, please explain:

____

____

PLEASE READ AND INITIAL THE FOLLOWING, AND SIGN BELOW:

□ I understand that this massage is not a replacement for medical care and that no diagnosis will be made.

□ I am responsible for paying for any appointment cancellation of less than 6 hours.

Signature: ______________________ Date: ______________________

INNOVATION WELLNESS

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 the Massage Therapist Association of Saskatchewan, Inc, and Natural Health Practitioners of Canada, 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 or 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.

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.

I agree to provide **6 hour** cancellation notice. If I fail to do so, I agree to pay the **50%** of the appointment fee

Signature of Patient/Guardian ______________________

Therapist Signature ______________________________

Date Signed___________________________