

MESSAGE PATIENT ENTRANCE FORM

Date _____ Circle: Male Female
 Name _____ Birth Date (D/M/Y) _____ Age _____
 Address _____ City _____ Province _____
 Postal Code _____ Home # _____ Cell # _____
 Occupation _____ Employer _____
 Work # _____ E-mail _____
 Name of Emergency Contact _____
 Contact # _____ Relation _____

Family Doctor & # _____ Surgeries/fractures &/or injuries: Y N
 Medications _____
 Other healthcare/practitioners: (Chiropractic, Exercises, etc.): _____

Prior Massage Therapy Care: Y N Reason for seeking care: _____
 Motor Vehicle Accident: Y N If Y, Date: _____
 Additional relevant information: _____

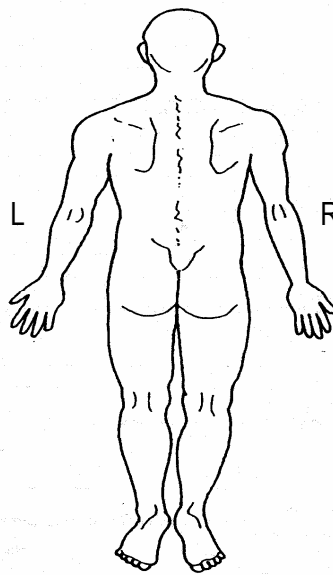
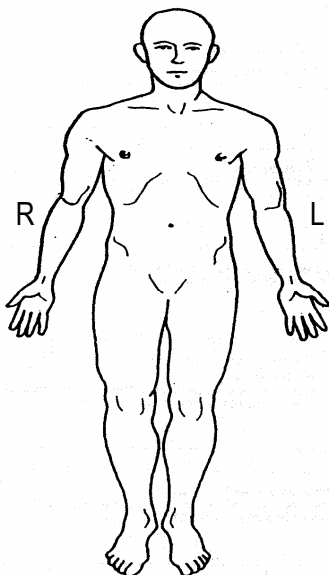
WHERE DO YOU FEEL YOUR PAIN?

Please use the appropriate symbol (s) below. Include all affected areas. If pain radiates, draw an arrow from where it starts to where it stops. Please extend the arrow as far as the pain travels.

Ache >>>>
 Burning x x x x x

Numbness = = = = =
 Stabbing / / / / / / / / /

Pins & Needles o o o o
 Throbbing ~ ~ ~ ~ ~ ~ ~



Health History Form

Please indicate conditions you are experiencing or have experienced:

<p><u>Cardiovascular</u></p> <p><input type="checkbox"/> high blood pressure</p> <p><input type="checkbox"/> low blood pressure</p> <p><input type="checkbox"/> chronic congestive heart failure</p> <p><input type="checkbox"/> heart attack</p> <p><input type="checkbox"/> phlebitis/varicose veins</p> <p><input type="checkbox"/> stroke/CVA</p> <p><input type="checkbox"/> pacemaker or similar device</p> <p><input type="checkbox"/> heart disease</p> <p>Is there a family history of any of the above?</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p><u>Respiratory</u></p> <p><input type="checkbox"/> chronic cough</p> <p><input type="checkbox"/> shortness of breath</p> <p><input type="checkbox"/> bronchitis</p> <p><input type="checkbox"/> asthma</p> <p><input type="checkbox"/> emphysema</p> <p>Is there a family history of any of the above?</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No</p>	<p><u>Infections</u></p> <p><input type="checkbox"/> hepatitis</p> <p><input type="checkbox"/> skin conditions</p> <p><input type="checkbox"/> TB</p> <p><input type="checkbox"/> HIV</p> <p><input type="checkbox"/> herpes</p> <p><u>Other Conditions</u></p> <p><input type="checkbox"/> loss of sensation, where? _____</p> <p><input type="checkbox"/> diabetes, onset: _____</p> <p><input type="checkbox"/> allergies/hypersensitivity to what? _____</p> <p><input type="checkbox"/> type of reaction: _____</p> <p><input type="checkbox"/> epilepsy</p> <p><input type="checkbox"/> cancer, where? _____</p> <p><input type="checkbox"/> skin conditions, what? _____</p> <p><input type="checkbox"/> arthritis</p> <p>Is there a family history of arthritis?</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No</p>	<p><u>Head/Neck</u></p> <p><input type="checkbox"/> history of headaches</p> <p><input type="checkbox"/> history of migraines</p> <p><input type="checkbox"/> vision problems</p> <p><input type="checkbox"/> vision loss</p> <p><input type="checkbox"/> ear problems</p> <p><input type="checkbox"/> hearing loss</p> <p><u>Women</u></p> <p><input type="checkbox"/> pregnant, due: _____</p> <p><input type="checkbox"/> gynecological conditions, what? _____</p> <p>Overall, how is your general health?</p> <p>_____</p> <p>Primary Care Physician: _____</p> <p>Address: _____</p> <p>_____</p> <p>_____</p>
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<p>Current Medications: _____</p> <p>Condition it treats: _____</p> <p>_____</p> <p>Are you currently receiving treatment from another health care professional? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>If yes, for what? _____</p> <p>_____</p> <p>Surgery – date _____</p> <p>Nature: _____</p> <p>Injury – date _____</p> <p>Nature: _____</p>	<p>Do you have any other medical condition? (e.g. digestive conditions, hemophilia, osteoporosis, mental illness) <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>What? _____</p> <p>Do you have any internal pins, wires, artificial joints or special equipment?</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>What? _____</p> <p>Where? _____</p> <p>What is the reason you are seeking massage therapy? Please include the location of any tissue or joint discomfort.</p> <p>_____</p> <p>_____</p> <p>_____</p>
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Confidential Consent Form for Massage Therapy

The massage therapist respects the patient's right to an informed and voluntary consent regarding care and treatment by obtaining his/her consent before providing treatment.

Your comfort and trust in this clinic is extremely important in providing an optimal patient/therapist relationship.

The treatment will be provided only when there is reasonable expectation that the treatment will be beneficial to the patient.

Before, during and/or after therapy, we encourage you to communicate to the therapist any aspect of the treatment in which you have concerns and/or questions.

Proper draping is always provided to ensure safety, comfort and privacy for all patients. Patients are asked to disrobe in private and prepare themselves on the massage table. You may choose to remove or leave on clothing, according to your own comfort level.

The massage therapist respects your right to modify, refuse, or terminate treatment, regardless of prior consent given.

This clinic respects the confidentiality of all patient information unless the law or court order requires disclosure. Information will not be released otherwise, unless written consent is obtained.

Massage Therapy Rates:

120 minutes - \$150.00
90 minutes - \$120.00
60 minutes - \$ 80.00
45 minutes - \$ 70.00
30 minutes - \$ 55.00

* Receipts issued upon payment

*******CANCELLATION POLICY***** PLEASE CALL THE OFFICE 12 HOURS IN ADVANCE TO CANCEL, AS SPACES FOR APPOINTMENTS ARE LIMITED. A 100% CHARGE OF THE MASSAGE FEE WILL BE APPLIED FOR "no shows" or last minute cancellations.**

****PAYMENT POLICY**** Payment is expected at the time of service.

I, _____ (print name) have read and understand the fee schedule, payment policy and cancellation policy for Massage Therapy services. I understand my rights to consent to treatment.

Signature

Date