INFORMED CONSENT TO MASSAGE THERAPY TREATMENT

I understand that the Registered Massage Therapist is providing massage therapy services within their scope of practice as defined by the College of Massage Therapists of Ontario (CMTO).

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 understand the cancellation policy, and that I must provide at least **48** hours' notice of cancellation of an appointment I am unable to attend. I understand that I will be charged the full fee for a missed appointment if proper cancellation notification is not provided. A scheduled appointment means that the therapist has reserved a time to see you and no other patients. When proper cancellation time is not provided they don't work and may not be able to replace your appointment with someone on the waiting list without proper notification.

Cash payment for services is due at the end of each treatment.

Receipts are emailed and provided within 24 hours of the treatment date.

Client Name ____________________________

Signature of Client/Guardian ____________________________

Therapist Name John Maynard

Therapist Signature ____________________________

Date Signed ____________________________

Massage Therapy Health History

Please fill out this health history form as completely as possible. The information gathered through your health history provides your massage therapist with necessary information to treat you safely. Please feel free to ask any questions about why we are requesting this information. The information you provide will be kept confidential unless you submit a written request for us to release your information or if required by law.

Date: ________________________________

Why Are You Here Today: ____________________________________

Please answer the following questions.

Name:	
Phone:	
Email:	
Address:_	
Date of Birth:	
Occupation:	
Emergency Contact:	
Phone:	
Were You Referred?	☐ Y ☐ N
Who Referred You?	
Doctors Name:	
Doctor's Phone:	
Are You In Pain?	☐ Y ☐ N ☐ Dull ☐ Sharp ☐ Shooting ☐ Achy ☐ Numb ☐ Tingling ☐ Stiff_
Pain Scale (low) ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10 (high)	
Does The pain Radiate?	
What Aggravates Symptoms?	
What Relieves Symptoms?	
When Did This Start?	
Does Condition Interfere With	☐ Work ☐ Sleep ☐ Daily ☐ Routine ☐ Activities ☐ Other
Have You Been Treated By	☐Physician☒Chiropractor☐Physiotherapist☐RMT☐Other
Did They provide Relief?	☐ Y ☐ N How/What
Any Pins, Wires or Artificial Jts	☐ Y ☐ N
Are You On Any Medications?	☐ Y ☐ N
Energy Level	☐ Low ☐ Average ☐ High
Do you Feel Stressed?	☐ Y ☐ N Cause?
Regular Exercise?	☐ Y ☐ N Type?
Regular Sleep?	☐ Y ☐ N How many hours per day?
Computer Use?	☐ Y ☐ N How many hours per day?
Mobile Device Use?	☐ Y ☐ N How many hours per day?
Notes:	

Please indicate conditions you are experiencing or have experienced:

Cardiovascular
□ high blood pressure
□ low blood pressure
□ chronic congestive heart failure
□ heart attack
□ stroke / CVA
□ phlebitis / varicose veins

Respiratory
□ chronic cough
□ shortness of breath
□ bronchitis
□ asthma
□ emphysema

Infections
□ hepatitis
□ skin conditions
____
□ TB
□ HIV
□ Other
____

Women
□ pregnant, due:________________
□ menstrual pain □ PMS
□ hormonal imbalances
□ gynecological conditions
____

Other Conditions
□ Diabetes type 1 □ Diabetes type 2
□ allergies/hypersensitivities
____
□ epilepsy
□ cancer, where?
____
□ skin conditions
____
□ arthritis □osteoarthritis □rheumatoid
□ family history of arthritis
□ chronic fatigue
□ fibromyalgia
□ depression □ anxiety □ bipolar
□ dizziness □ fatigue □ memory loss
□ sleep problems
□ concentration problems

Head / Neck
□ history of headaches
□ history of migraines
□ vision problems / vision loss
□ ear problems / hearing loss

Musculoskeletal
□ strains:
____
____
□ sprains:
____
____
□ fractures:
____
□ dislocations:
____
□ loss of sensation:
____
□ degenerative disc:
____
□ scoliosis
□ nerve problems:
____

Additional Information That May Be Relevant: