



Insurance:	Co-pay/deduct:
ID #	Max \$ / treatmnt:
Group #	Max \$ / year:
Dr.'s prescript:	Other:

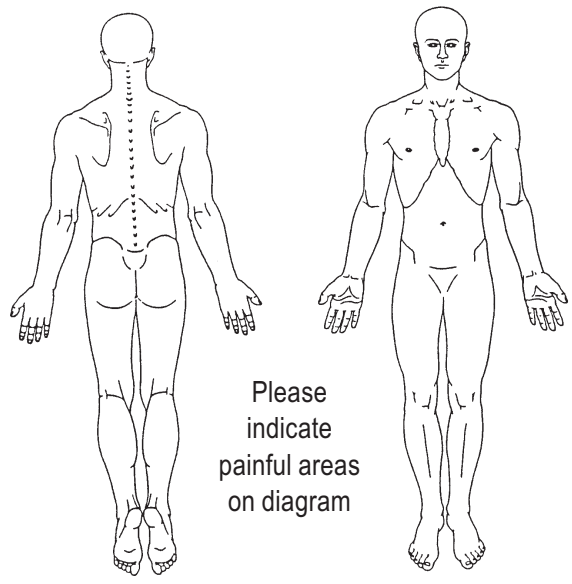
**PATIENT CARE RECORD**

Name \_\_\_\_\_ Date \_\_\_\_\_  
 Address \_\_\_\_\_ Postal code \_\_\_\_\_  
 Phone: Home \_\_\_\_\_ Work \_\_\_\_\_ Cell \_\_\_\_\_  
 Date of birth \_\_\_\_\_ Height \_\_\_\_\_ Weight \_\_\_\_\_  
 Occupation \_\_\_\_\_ Hours per day \_\_\_\_\_  
 Type of exercise \_\_\_\_\_  
 Where did you hear about our clinic? \_\_\_\_\_  
 Previous massage experience:  Yes  No Frequency \_\_\_\_\_  
 Reason for coming:  Relaxation  Pain relief Other \_\_\_\_\_  
 Family doctor: Name \_\_\_\_\_ Address \_\_\_\_\_ Phone \_\_\_\_\_

**Please check any of the conditions below that you experience now or have in the past:**

- |                                    |                                     |  |  |                                     |
|------------------------------------|-------------------------------------|--|--|-------------------------------------|
| <input type="radio"/> Epilepsy     | <input type="radio"/> Cancer        | <input type="radio"/> Shortness of Breath        | <input type="radio"/> Bruise Easily    | <input type="radio"/> Sciatica      |
| <input type="radio"/> Anemia       | <input type="radio"/> Asthma        | <input type="radio"/> Varicose Veins (Phlebitis) | <input type="radio"/> Constipation     | <input type="radio"/> Stroke        |
| <input type="radio"/> Diabetes     | <input type="radio"/> Emphasema     | <input type="radio"/> Sensitive Skin             | <input type="radio"/> Fluid Retention  | <input type="radio"/> Heart Disease |
| <input type="radio"/> Tuberculosis | <input type="radio"/> Bronchitis    | <input type="radio"/> Skin Conditions            | <input type="radio"/> Neck / Back Pain | <input type="radio"/> Pacemaker     |
| <input type="radio"/> HIV / Aids   | <input type="radio"/> Chronic Cough | <input type="radio"/> Indigestion/Abdominal Pain | <input type="radio"/> Leg Cramps       | <input type="radio"/> Vision Loss   |
| <input type="radio"/> Hepatitis    | <input type="radio"/> Smoker        | <input type="radio"/> Anaphylactic Reaction      | <input type="radio"/> Painful joints   | <input type="radio"/> Hearing Loss  |

High/low blood pressure \_\_\_\_\_  
 Communicable disease \_\_\_\_\_  
 Number of colds per year \_\_\_\_\_  
 Allergies (including scent allergies) \_\_\_\_\_  
 Headaches: How often? \_\_\_\_\_  
 Where? \_\_\_\_\_  
 Limited movement \_\_\_\_\_  
 Present painful area \_\_\_\_\_  
 Chronic painful area \_\_\_\_\_  
 Arthritis \_\_\_\_\_  
 Recent surgery \_\_\_\_\_  
 Fractures/pins/wires \_\_\_\_\_  
 Artificial joints or limbs \_\_\_\_\_  
 Are you pregnant? \_\_\_\_\_  
 Other \_\_\_\_\_  
 Medications (include ailment) \_\_\_\_\_  
 Current involvement with other health care professionals \_\_\_\_\_  
 Injuries/accidents (timing/nature) \_\_\_\_\_  
 \_\_\_\_\_



Last Name: \_\_\_\_\_

First Name: \_\_\_\_\_



## INFORMED CONSENT

Please read the following and sign and date at the bottom if you have understood the statements:

- The purpose of treatment is to develop, maintain, rehabilitate or augment physical functioning, relieve or prevent physical dysfunction and pain and to enhance your well being.
- Massage therapy is the assessment of the soft tissues and joints of the body and their treatment by means of soft tissue manipulations, hydrotherapy, remedial exercise programs, and self-care programs.
- We require a general health history from you. Upon completion, an assessment of your needs and a treatment plan is formulated between you and your therapist. This includes desired health outcome, frequency of treatment, type of treatment, alternate courses of treatment and client self-care programs.
- Your records are confidential. We require written authorization from you prior to any release of information.
- In the event your therapist is not available your records will be available to an alternate therapist of your choice for that treatment.
- Areas of the body to be treated will be discussed prior to treatment. Your therapist will explain reasons for and ask for consent before applying massage in the chest area.
- The genital / perineum areas are not massaged.
- All areas of the body remain draped except for the area currently being worked on.
- You have the right to refuse, modify or terminate treatment at any time.  
You have the right to inspect the clinic prior to treatment.
- I have been informed of the fee schedule and payment is due in cash or cheque at the time of treatment. (Direct billing is available for Green Shield clients)
- **We require 24 hours notice for appointment cancellations.** Your therapist may choose to bill you for missed appointments or less than 24 hours notice of cancellation.
- I have read the above and feel that I may make an informed choice.

**Date:**

**Signature:**

Last Name:

First Name: