MASSAGE THERAPY CENTRE
www.massagetherapycentre.com

PATIENT CARE RECORD

Updated: _____

Insurance:	Co-pay/deduct:
#:	Max $ / treatment:
#:	Max $ / year:
Dr.'s prescript:	Other:

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:

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

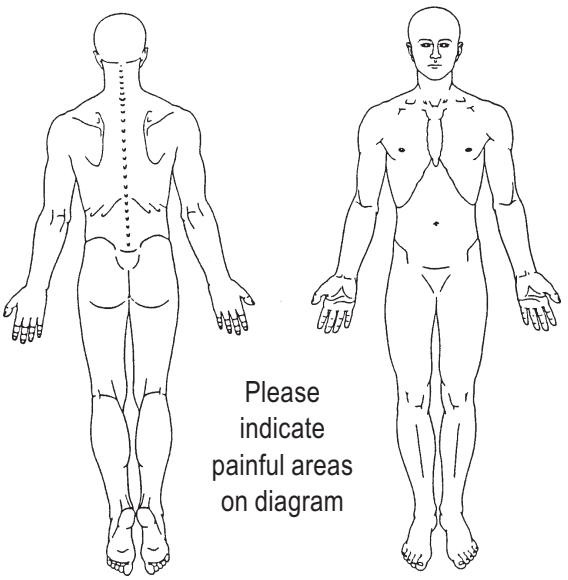
Recent surgery _____

Fractures/pins/wires _____

Artificial joints or limbs _____

Are you pregnant? _____

Other _____



Please indicate painful areas on diagram

Medications (include ailment) _____

Current involvement with other health care professionals _____

Injuries/accidents (timing/nature) _____

_____

Last Name: _____ First Name: _____

MASSAGE THERAPY CENTRE
THERAPEUTIC & RELAXATIONAL MASSAGE
www.massagetherapycentre.com
519-434-3946

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 at the time of treatment.
  (Direct billing may be available for some insurance plans.)
- **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: _____