Massage Works

I understand that the following information is strictly confidential and is necessary for my therapist to be fully aware of my health status prior to treatment. Information gathered for this treatment is confidential except as required or allowed by law to facilitate diagnosis or treatment. You will be asked to provide written authorization for release of any information.

Name: _____ Date: _____ Date of Birth: _____

Address: _____

Home Phone: _____ Cell: _____ Work: _____

May we contact you? ☐ YES ☐ NO

Email: _____

Occupation: _____ Chiropractor: _____

Physician: _____ Address: _____

Please Indicate conditions you have had or are experiencing:

Respiratory
- ☐ chronic cough
- ☐ bronchitis
- ☐ asthma
- ☐ emphysema

Cardiovascular
- ☐ high blood pressure
- ☐ low blood pressure
- ☐ varicose veins
- ☐ CCHF
- ☐ hemophilia
- ☐ heart attack/disease
- ☐ plebitis
- ☐ stroke/CVA
- ☐ pacemaker or similar device, internal pins, wires or plates

Women
- ☐ pregnant due_____
- ☐ menopause

Infections
- ☐ HIV or AIDS
- ☐ TB
- ☐ skin conditions
- ☐ hepatitis

Head/Neck
- ☐ vision problems
- ☐ vision loss
- ☐ hearing problems
- ☐ hearing loss
- ☐ headaches

Other Conditions
- ☐ cancer
- ☐ allergies i.e. skin irritation Or anaphylaxis
- ☐ loss of sensation

Digestive/Uro-Genital
- ☐ constipation
- ☐ diarrhea
- ☐ hernia
- ☐ diabetes (onset_____)
- ☐ urinary problems
- ☐ other_____

Muscles and Joints
- ☐ arthritis
- ☐ neck/shoulders
- ☐ low back
- ☐ mid back
- ☐ arms/legs
- ☐ knees
- ☐ fibromyalgia
- ☐ other

What is your general health status? _____

Other medical conditions (e.g Digestive or gynecological?)

_____

Do you wear any of the following? ☐ Dentures ☐ Contact Lenses ☐ Prosthesis

Previous massage experience? ☐ YES ☐ NO

Previous reaction (if any) to massage: _____

What is your primary complaint? _____

Are you currently experiencing pain? If so, where?

_____

Does anything relieve and/or aggravate the pain?

_____

Are you currently seeking treatment? _____

Is the pain getting worse? ☐ YES ☐ NO ☐ SAME ☐ COMES AND GOES

Current medications: _____

Condition it treats: _____

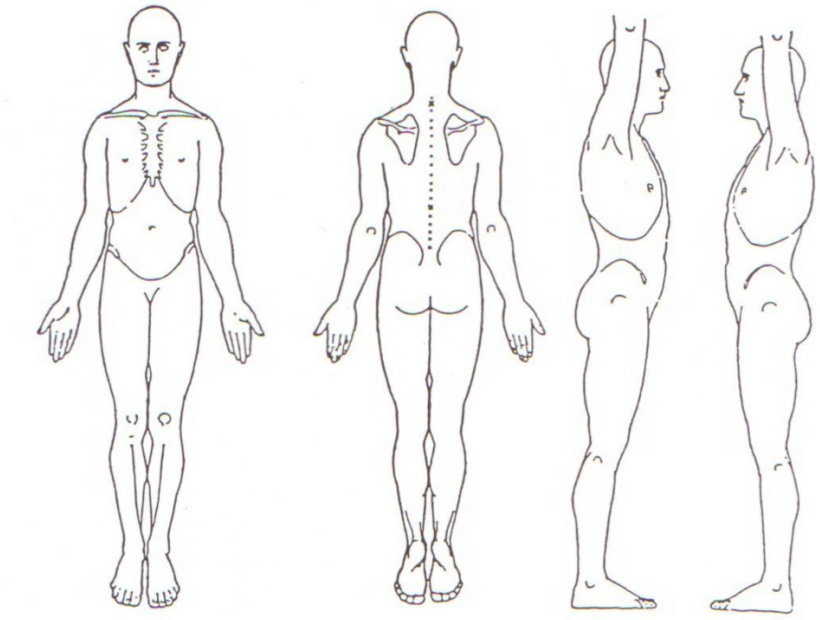
Surgery: _____ Date: _____ Nature: _____

Injury: _____ Date: _____ Nature: _____

How did you hear about Massage Therapy at this location?

_____

Please shade in the areas of tension and/or pain:



Consent to Treatment Form

I acknowledge that my therapist has informed me with such information that is pertinent to the treatment of the above-listed condition. I feel that I fully understand what is involved in the proposed treatment and what the possible consequences of not having a treatment may be. I acknowledge that, for the purpose of integrated therapy, the following areas may be addressed during the course of the treatment: head, neck, shoulders, upper chest, arms, back, hips, buttocks, hands, feet and legs.

These are the areas that I give permission to be addressed during the course of the treatment: (please indicate your choices).

☐ head ☐ neck/shoulders ☐ upper chest ☐ arms

☐ back/hips ☐ buttocks ☐ legs ☐ hands/feet

☐ all of the above

Treatment Costs

½ Hour ……. $50

1 Hour ……. $85

3/4 Hour ……. $70

1½ Hour ……. $120

ART

10 Minutes ……. $25

20 Minutes ……. $45

30 Minutes ……. $65

Cancellations without 24 hours notice (first missed appointment) … $25.00
24 Hours notice is required for all cancellations. Failure to do so will result in a first time fee of $25.00 and subsequent missed appointments will be charged in full. Payment may be made with cash, cheque, VISA or Mastercard following the treatment in full. Prices include HST and may be changed without notice.

Please review the privacy policy (below) prior to signing this form.
I am aware of my rights, and I provide my full, voluntary informed consent regarding treatment, and the privacy policy in effect.

Name (please print): _____

Signature: _____

Date: _____

Privacy Policy

1. **Accountability**: Massage Works, Registered Massage Therapy Clinic is solely responsible for all personal information entrusted in writing, as well as all information pertaining to the client. For example, health history and ongoing treatment forms.
2. **Identifying Purpose**: The purpose for which Massage Works collects personal information of clients, including a complete health history, medical information, address, physical condition and function as well as social situations pertaining to the condition is:
    - To assess their health needs
    - To understand a family history regarding their condition
    - To send mail to the individual
    - To facilitate assessment or treatment
    - To formulate a pertinent treatment plan
    - To inquire whether a member is implicated
3. **Consent:** Consent is received prior to any treatments related to the main concern. Consent and knowledge of the information for the collection, use or other health care professionals, information may be verbally passed on to them without the client being aware. The individual prior to the release must approve all written information.
4. **Limiting Collection**: Collection of personal information will be that which is required for direct client care outlined in principle 2.
5. **Limiting Use, Disclosure or Retention:** The information collected is strictly confidential except as required or allowed by law. Information shall not be used, distributed or allowed for any purposes other than outlined in principle 2. Personal information of the individual will be retained only as long as required by law.
6. **Accuracy:** Personal information will be taken on the initial treatment date. It will be the most accurate and up to date information as possible. Prior to each treatment, any pertinent information will be added to the TX file. Clients will fill out a new health history form each year to ensure accuracy.
7. **Safeguards:** Personal information is protected by the following;
    - Paper information is kept in a secure, locked filing cabinet or under supervision.
    - Paper information is transmitted through sealed envelopes
    - Information no longer required is disposed of in a confidential fashion.
8. **Openness:** Individuals may have all information on policies and practices regarding confidential information by reading the clinic's privacy policy.
9. **Individual Access:** Upon request, individuals will be informed of any disclosure or use of information as facilitated by law. Individuals may review their information and may challenge the accuracy and completeness, or have the information amended.
10. **Challenging Compliance:** If an individual has an issue concerning this privacy policy, any questions should be directed to the designated individual stated in privacy code #1.