

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 of Birth: _____		Date: _____	
Address: _____					
Home Phone: _____		Cell: _____		Work: _____	
Email: _____				May we contact you? <input type="checkbox"/> YES <input type="checkbox"/> NO	
Physician: _____		Location: _____		Physicians phone #: _____	
May we contact your Health Care Professionals? <input type="checkbox"/> YES <input type="checkbox"/> NO				Chiropractor: _____	
Physiotherapist: _____		Alternative Health Care professionals: _____			
Present Involvement of other Health Care for this? <input type="checkbox"/> YES <input type="checkbox"/> NO Please Explain: _____					

Did you receive a referral from a health care provider for massage today? YES NO From _____

How did you hear about Massage Therapy at this location? _____

Current medications: _____	Condition it treats: _____
_____	Condition it treats: _____
_____	Condition it treats: _____
_____	Condition it treats: _____
_____	Condition it treats: _____

Surgeries: _____	Date: _____	Nature: _____
_____	Date: _____	Nature: _____
_____	Date: _____	Nature: _____
_____	Date: _____	Nature: _____

Injuries: _____	Date: _____	Nature: _____
_____	Date: _____	Nature: _____

Please Indicate conditions you have had or are experiencing:

Lifestyle	Cardiovascular	Head/Neck/Eyes/Ears/Nose/Throat
Occupation: _____	<input type="checkbox"/> High Blood Pressure: ____ / ____	<input type="checkbox"/> Vision problems
General health status: _____	<input type="checkbox"/> Low Blood Pressure: ____ / ____	<input type="checkbox"/> Vision loss
Current Activity level: _____	<input type="checkbox"/> Varicose veins	<input type="checkbox"/> Vertigo
Hobbies/sports: _____	<input type="checkbox"/> CCHF	<input type="checkbox"/> Eye pain
_____	<input type="checkbox"/> Hemophilia	<input type="checkbox"/> Hearing loss
Do you suffer from stress regularly?	<input type="checkbox"/> Heart Attack: When/Type? _____	<input type="checkbox"/> Hearing problems _____
<input type="checkbox"/> Yes <input type="checkbox"/> No	_____	<input type="checkbox"/> Tinnitus (ringing in ears)
Hours using a computer or working at a desk per day? _____	<input type="checkbox"/> Heart disease _ _____	<input type="checkbox"/> Ear Aches & Infections
Hours of commute/drive per day? _____	<input type="checkbox"/> Phlebitis	<input type="checkbox"/> Hearing Aid
Do you sleep well? <input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> TIA / Stroke / CVA	<input type="checkbox"/> Nasal Bleeds / Obstruction
Hours per night? ____ Position: _____	<input type="checkbox"/> Heart murmur / Palpitations	<input type="checkbox"/> Sinus Infections
Energy Level: <input type="checkbox"/> High <input type="checkbox"/> Med <input type="checkbox"/> Low	<input type="checkbox"/> High Cholesterol	<input type="checkbox"/> Headaches _____
Do you wear any of the following?	<input type="checkbox"/> Blood Clots	Frequency/duration _____
<input type="checkbox"/> Orthotics <input type="checkbox"/> Braces/Supports	<input type="checkbox"/> Poor Circulation	<input type="checkbox"/> Migraines _____
<input type="checkbox"/> Dentures <input type="checkbox"/> Contact Lenses	<input type="checkbox"/> Pacemaker / Similar Device	Symptoms _____
<input type="checkbox"/> Prosthesis <input type="checkbox"/> Glasses	Date/Type _____	<input type="checkbox"/> Concussions _____
<input type="checkbox"/> Hearing Aid <input type="checkbox"/> Implants	<input type="checkbox"/> Other _____	Symptoms _____
	<input type="checkbox"/> Family History of any (which & who): _____	<input type="checkbox"/> Family History of any (which & who): _____
	_____	_____

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<p style="text-align: center;">Respiratory</p> <input type="checkbox"/> Chronic cough <input type="checkbox"/> Bronchitis <input type="checkbox"/> Asthma <input type="checkbox"/> Emphysema <input type="checkbox"/> Shortness of Breath <input type="checkbox"/> Smoker _____ / day <input type="checkbox"/> Pneumonia <input type="checkbox"/> Hay fever <input type="checkbox"/> Wheezing <input type="checkbox"/> Other _____ <input type="checkbox"/> Family History of any (which & who) _____ _____	<p style="text-align: center;">Infections / Skin</p> <input type="checkbox"/> Bruises Easily <input type="checkbox"/> HIV or AIDS <input type="checkbox"/> TB (tuberculosis) <input type="checkbox"/> Hepatitis Onset : _____ <input type="checkbox"/> Herpes <input type="checkbox"/> Eczema _____ <input type="checkbox"/> Athletes Foot _____ <input type="checkbox"/> Warts _____ <input type="checkbox"/> Fungal Infections _____ <input type="checkbox"/> Skin conditions _____ <input type="checkbox"/> Other _____	<p style="text-align: center;">Women</p> <input type="checkbox"/> Pregnant: Due _____ <input type="checkbox"/> Menopause <input type="checkbox"/> PCOS <input type="checkbox"/> Endometriosis <input type="checkbox"/> Yeast Infections <input type="checkbox"/> Previous pregnancies _____ Births/deliveries _____ <input type="checkbox"/> Other Gynaecological Conditions _____ <input type="checkbox"/> Family History of any (which & who) _____ _____
<p style="text-align: center;">Digestive/Urogenital/Gastrointestinal</p> <input type="checkbox"/> Constipation <input type="checkbox"/> Diarrhea <input type="checkbox"/> Hernia <input type="checkbox"/> Diabetes: Onset: _____ Pump?: _____ <input type="checkbox"/> IBS <input type="checkbox"/> Diverticulitis <input type="checkbox"/> Crohn's <input type="checkbox"/> Colitis <input type="checkbox"/> Nausea / Vomiting <input type="checkbox"/> Ulcers <input type="checkbox"/> Acid Reflux <input type="checkbox"/> Bloating / Gas <input type="checkbox"/> Gallbladder <input type="checkbox"/> Kidney Stones / Infections <input type="checkbox"/> Urinary / Bladder Infections <input type="checkbox"/> Blood in Urine <input type="checkbox"/> Incontinence (unable to control urination) <input type="checkbox"/> Difficulty urinating <input type="checkbox"/> Other _____ <input type="checkbox"/> Family History of any (which & who): _____ _____	<p style="text-align: center;">General / Other Conditions</p> <input type="checkbox"/> Loss of Sleep <input type="checkbox"/> Sudden Weight Loss <input type="checkbox"/> Night Sweats <input type="checkbox"/> Sleep Apnea <input type="checkbox"/> Autoimmune _____ <input type="checkbox"/> Epilepsy <input type="checkbox"/> Seizures _____ <input type="checkbox"/> Cancer _____ _____ <input type="checkbox"/> Allergies/Hypersensitivity (skin irritation, anaphylaxis) _____ <input type="checkbox"/> Anxiety <input type="checkbox"/> Depression <input type="checkbox"/> Eating Disorders _____ <input type="checkbox"/> Mental Illness _____ <input type="checkbox"/> Loss of sensation _____ <input type="checkbox"/> Other medical conditions _____ <input type="checkbox"/> Family History of any (which & who): _____ _____	<p style="text-align: center;">Muscles / Joints / Skeletal</p> <input type="checkbox"/> Fibromyalgia <input type="checkbox"/> Arthritis: Type: _____ Location: _____ <input type="checkbox"/> Osteoporosis <input type="checkbox"/> Degenerative Disc Disease <input type="checkbox"/> Herniated Disc: Which _____ <input type="checkbox"/> Scoliosis <input type="checkbox"/> Sciatica: Which Leg? <input type="checkbox"/> Left <input type="checkbox"/> Right <input type="checkbox"/> Neck <input type="checkbox"/> Jaw / TMJ Dysfunction <input type="checkbox"/> Mid back <input type="checkbox"/> Torso <input type="checkbox"/> Low back <input type="checkbox"/> Buttocks <input type="checkbox"/> Hips <input type="checkbox"/> Shoulders <input type="checkbox"/> Arms <input type="checkbox"/> Hands <input type="checkbox"/> Knees <input type="checkbox"/> Legs <input type="checkbox"/> Feet <input type="checkbox"/> Artificial Joints, replacements; _____ <input type="checkbox"/> Internal pins, wires or plates. What: _____ Where: _____ <input type="checkbox"/> Other _____ <input type="checkbox"/> Family History of any (which & who): _____ _____

Previous massage experience? YES NO

Please shade in areas of tension/pain below:

Reaction (if any) to massage: _____

What is your primary complaint? _____

Are you currently experiencing pain? YES NO Where? _____ →

Please describe it: _____

Does it radiate anywhere? YES NO Where? _____

Please describe it: _____

When / How did this start? _____

How often do you feel this discomfort? _____

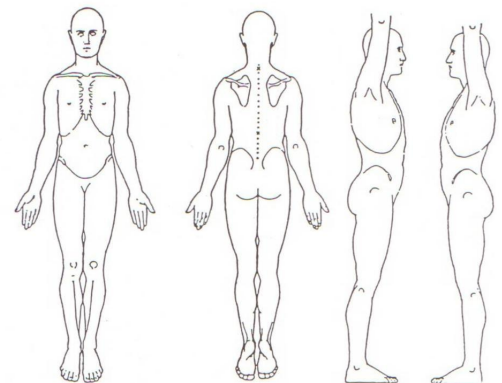
How long does this pain last? _____

Does anything relieve the pain? _____

Aggravate it? _____

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

Any other comments? _____



Massage Works

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.

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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/treated during the course of the treatment: (please indicate your choices).

- Head Face Neck Shoulders Arms Hands
- Back Hips Legs Feet Abdomen All of the above

(See special consent form for Consent to Sensitive Areas)

Treatment Costs

¼ Hour \$25.00

½ Hour \$55.00

¾ Hour \$75.00

1 Hour \$90.00

75 Min \$115.00

1.5 Hour \$130.00

Hot Rock

1 Hr hot rock \$120.00

1.5 Hr hot rock \$165.00

On-Site requires 3 hr minimum *& some exceptions apply

1 Hr On-Site \$130.00

1.5 Hr On-Site \$180.00

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: _____