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? ☐YES ☐NO

Physician: _____ Location:_____ Physicians phone #: _____

May we contact your Health Care Professionals? ☐YES ☐NO Chiropractor: _____

Physiotherapist: _____ Alternative Health Care professionals: _____

Present Involvement of other Health Care for this? ☐YES ☐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

Occupation: _____
General health status: _____
Current Activity level: _____
Hobbies/sports: _____
_____
Do you suffer from stress regularly?
☐Yes ☐No
Hours using a computer or working at a desk per day? _____
Hours of commute/drive per day? _____
Do you sleep well? ☐Yes ☐No
Hours per night? ___ Position:
Energy Level: ☐High ☐Med ☐Low

Do you wear any of the following?
☐ Orthotics ☐ Braces/Supports
☐ Dentures ☐ Contact Lenses
☐ Prosthesis ☐ Glasses
☐ Hearing Aid ☐ Implants

Cardiovascular

☐ High Blood Pressure: _____ / _____
☐ Low Blood Pressure: _____ / _____
☐ Varicose veins
☐ CCHF
☐ Hemophilia
☐ Heart Attack: When/Type? _____
_____
☐ Heart disease _____
☐ Phlebitis
☐ TIA / Stroke / CVA
☐ Heart murmur / Palpitations
☐ High Cholesterol
☐ Blood Clots
☐ Poor Circulation
☐ Pacemaker / Similar Device
Date/Type _____
☐ Other _____
☐ Family History of any (which & who):
_____

Head/Neck/Eyes/Ears/Nose/Throat

☐ Vision problems
☐ Vision loss
☐ Vertigo
☐ Eye pain
☐ Hearing loss
☐ Hearing problems _____
☐ Tinnitus (ringing in ears)
☐ Ear Aches & Infections
☐ Hearing Aid
☐ Nasal Bleeds / Obstruction
☐ Sinus Infections
☐ Headaches _____
Frequency/duration _____
☐ Migraines _____
Symptoms _____
☐ Concussions_____
Symptoms _____
☐ Family History of any (which & who):
_____

Massage Works

Respiratory
- ☐ Chronic cough
- ☐ Bronchitis
- ☐ Asthma
- ☐ Emphysema
- ☐ Shortness of Breath
- ☐ Smoker _____ / day
- ☐ Pneumonia
- ☐ Hay fever
- ☐ Wheezing
- ☐ Other _____
- ☐ Family History of any (which & who)

_____

Infections / Skin
- ☐ Bruises Easily
- ☐ HIV or AIDS
- ☐ TB (tuberculosis)
- ☐ Hepatitis ____ Onset :_____
- ☐ Herpes
- ☐ Eczema _____
- ☐ Athletes Foot _____
- ☐ Warts _____
- ☐ Fungal Infections _____
- ☐ Skin conditions _____
- ☐ Other _____

Women
- __ Pregnant: Due_____
- __ Menopause
- __ PCOS
- __ Endometriosis
- __ Yeast Infections
- __ Previous pregnancies _____
  Births/deliveries _____
- __ Other Gynaecological Conditions

_____
- __ Family History of any (which & who)

_____

Digestive/Urogenital/Gastrointestinal
- ☐ Constipation
- ☐ Diarrhea
- ☐ Hernia
- ☐ Diabetes:
  Onset: _____ Pump?: _____
- ☐ IBS
- ☐ Diverticulitis
- ☐ Crohn's
- ☐ Colitis
- ☐ Nausea / Vomiting
- ☐ Ulcers
- ☐ Acid Reflux
- ☐ Bloating / Gas
- ☐ Gallbladder
- ☐ Kidney Stones / Infections
- ☐ Urinary / Bladder Infections
- ☐ Blood in Urine
- ☐ Incontinence (unable to control urination)
- ☐ Difficulty urinating
- ☐ Other _____
- ☐ Family History of any (which & who):

_____

General / Other Conditions
- ☐ Loss of Sleep
- ☐ Sudden Weight Loss
- ☐ Night Sweats
- ☐ Sleep Apnea
- ☐ Autoimmune _____
- ☐ Epilepsy
- ☐ Seizures _____
- ☐ Cancer _____

_____
- ☐ Allergies/Hypersensitivity
  (skin irritation, anaphylaxis)

_____

_____
- ☐ Anxiety
- ☐ Depression
- ☐ Eating Disorders _____
- ☐ Mental Illness _____
- ☐ Loss of sensation _____
- ☐ Other medical conditions

_____
- ☐ Family History of any (which & who):

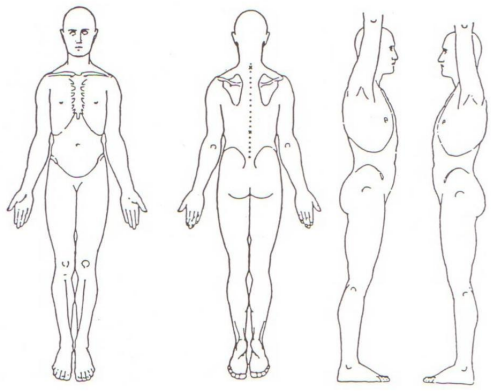
_____

Muscles / Joints / Skeletal
- ☐ Fibromyalgia
- ☐ Arthritis: Type: _____
  Location: _____
- ☐ Osteoporosis
- ☐ Degenerative Disc Disease
- ☐ Herniated Disc: Which --
- ☐ Scoliosis
- ☐ Sciatica: Which Leg? ☐Left ☐Right
- ☐ Neck ☐ Jaw / TMJ Dysfunction
- ☐ Mid back ☐ Torso / Ribcage
- ☐ Low back ☐ Buttocks
- ☐ Hips ☐ Shoulders
- ☐ Legs ☐ Arms
- ☐ Knees ☐ Wrists
- ☐ Feet ☐ Hands
- ☐ Artificial Joints, replacements; _____
- ☐ Internal pins, wires or plates.
  What: _____
  Where: _____
- ☐ Other _____
- ☐ Family History of any (which & who):

_____

Previous massage experience? ☐ YES ☐ NO
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? _____

Please shade in areas of tension/pain below:



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.

Massage Works

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, Interact 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): _____

Date: _____

Signature: _____