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: _______________ Physicians Address:________________ Physicians phone #: _____________

May we contact Health 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	Cardiovascular	Head/Neck/Eyes/Ears/Nose/Throat
Occupation: ____________________	☐ High Blood Pressure: normal: ___/____	☐ Vision problems
General health status: _______________	☐ Low Blood Pressure: normal: ___/____	☐ Vision loss
Current Activity level: _______________	☐ Varicose veins	☐ Vertigo
Hobbies/sports: ___________________	☐ CCHF	☐ Eye pain
___________________________	☐ Hemophilia	☐ Hearing loss
Do you suffer from stress regularly? ☐Yes ☐No	☐ Heart Attack: When/Type? _________ ___________________________	☐ Hearing problems: _______________
Hours using a computer or working at a desk per day? _______	☐ Heart disease: __________________	☐ Tinnitus (ringing in ears)
Hours of commute/drive per day? ______	☐ Phlebitis	☐ Ear Aches & Infections
Do you sleep well? ☐Yes ☐No	☐ TIA / Stroke / CVA	☐ Hearing Aid
Hours per night? ___ Position: _______	☐ Heart murmur / Palpitations	☐ Nasal Bleeds / Obstruction
Energy Level: ☐High ☐Med ☐Low	☐ High Cholesterol	☐ Sinus Infections
	☐ Blood Clots	☐ Headaches: Type/location___________ Frequency/duration______________
Do you wear any of the following?	☐ Poor Circulation	☐ Migraines: Frequency_____________ Symptoms ______________________
☐ Orthotics ☐ Braces/Supports	☐ Pacemaker / Similar Device? Date/Type: _____________	☐ Concussions: Dates _______________ Symptoms ______________________
☐ Dentures ☐ Contact Lenses	☐ Other: ________________________	
☐ Prosthesis ☐ Glasses	☐ Family History of any (which & who): ______________________________	☐ Family History of any (which & who): ______________________________
☐ Hearing Aid ☐ Implants		

Massage Works

Respiratory	Infections / Skin	Women
☐ Chronic cough ☐ Bronchitis ☐ Asthma ☐ Emphysema ☐ Shortness of Breath ☐ Smoker: Amount? ______________ ☐ Pneumonia ☐ Hay fever ☐ Wheezing ☐ Other: ________________________ ☐ Family History of any: (which & who) ______________________________	☐ HIV or AIDS ☐ TB (tuberculosis) ☐ Hepatitis: A B C Onset :_____ ☐ Herpes ☐ Bruise Easily ☐ Eczema: Where? _______________ ☐ Athletes Foot: Where? ____________ ☐ Warts: Where? ________________ ☐ Fungal Infections? Where? ________ ☐ Skin conditions: What? ___________ ☐ Other: ________________________	☐ Pregnant: Due___________ ☐ Menopause ☐ PCOS ☐ Endometriosis ☐ Yeast Infections ☐ Previous pregnancies. How many? ___ Births/deliveries _______ ☐ Other Gynaecological Conditions: ___ ______________________________ ☐ Family History of any: (which & who) ______________________________
Digestive/Urogenital/Gastrointestinal	**General / Other Conditions**	**Muscles / Joints / Skeletal**
☐ Constipation ☐ Diarrhea ☐ Hernia ☐ Diabetes: Type I Type II 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 ☐ Difficulty urinating ☐ Other ________________________ ☐ Family History of any (which & who): ______________________________	☐ Loss of Sleep ☐ Sudden Weight Loss ☐ Night Sweats ☐ Bruises Easily ☐ Autoimmune: ________________ ☐ Epilepsy ☐ Seizures: Type: ______________ ☐ Cancer: type/onset/status: _________ ______________________________ ☐ Allergies/Hypersensitivity (skin irritation, anaphylaxis) To what? ______________________ Reaction ______________________ ☐ Anxiety ☐ Depression ☐ Eating Disorders: _______________ ☐ Mental Illness: _________________ ☐ Loss of sensation. Where?_________ ☐ Other medical conditions: _________ ______________________________ ☐ Family History of any (which & who): ______________________________	☐ Fibromyalgia ☐ Arthritis: Type: _______________ Location: ____________________ ☐ Osteoporosis ☐ Degenerative Disk Disease ☐ Herniated Disk: Which ___________ ☐ Scoliosis ☐ Sciatica: Which Leg? ☐Left ☐Right ☐ Neck ☐ Jaw / TMJ Dysfunction ☐ Mid back ☐ Torso ☐ Low back ☐ Buttocks ☐ Hips ☐ Shoulders ☐ Arms ☐ Hands ☐ Knees ☐ Legs ☐ Feet ☐ Artificial Joints ☐ 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? ______________________________

When / How did this start? ______________________________

Are you currently experiencing pain? ☐YES ☐NO Where? ________ →

Please describe it: ______________________________

Does it radiate anywhere? ☐YES ☐NO Where? ______________

Please describe it: ______________________________

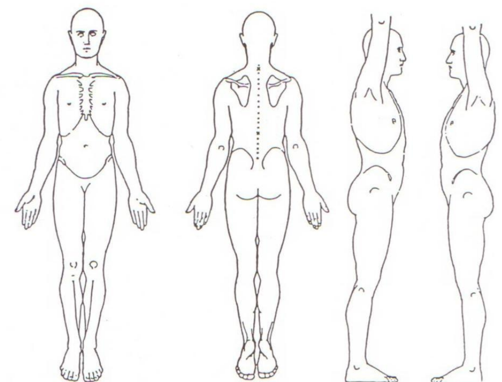
How long does this pain last? ______________________________

How often do you feel this discomfort? ______________________

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
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: ____

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.