MASSAGE THERAPY

OFFICE PROCEDURE CONSENT

PLEASE READ CAREFULLY AND THOROUGHLY

I hereby request and consent to massage therapy and other related procedures.

I have discussed with the therapist and/or with other office or clinic personnel the nature and purpose of therapeutic massage and other related procedures. I understand that results will vary depending on the individual and the extent of their condition.

I understand and am informed that, as in all health care, there are some risks to treatment that will be discussed before the treatment, if applicable. I wish to rely on the therapist to exercise judgment during the course of the procedure, based upon facts then known.

At Health Care Center, we value you as a friend and patient. We strive to provide a relaxing, educating and healthful atmosphere. Our therapist treats everyone with respect and trust and deserves the same in return. She works a limited number of hours each week to ensure the best possible care. Under these conditions, the Center must reserve the right to charge the full fee for a missed appointment with less than twenty-four (24) hours notice. Also, the Center reserves the right to charge the full scheduled fee for tardiness of appointments and/or request that appointments be secured by Visa or MasterCard.

I have read the above and have had an opportunity to ask questions about its content.

FEES:	60-minute massage	$ 80.00 (tax included)
	30-minute massage	$ 45.00 (tax included)

Patient _____

Signature _____ Date _____

FOR OFFICE USE ONLY

VISA/MC #_____ Exp. _____

CONFIDENTIAL CASE HISTORY
MASSAGE THERAPY

HEALTH CARE CENTER

Date: _____

Email address: _____

PATIENT INFORMATION

Last Name:	First Name:		Middle initial:
Address:	City and State:		Postal Code:
Home Phone Number:	Work Phone Number:		Occupation:
Date of Birth:	Male ☐ Female ☐	Marital Status: M ☐ W ☐ S ☐ D ☐	Number of Children: _____
How did you hear about us?	Do you have EXTENDED HEALTH CARE INSURANCE for massage therapy? ☐ Yes ☐ No	Is this your first massage? ☐ Yes ☐ No If no, previous R.M.T.'s name?	Is this: ☐ MVA ☐ WCB
Medical Doctor's Name		Doctor's Phone Number	

Reason for consulting massage therapist:

- ☐ I have no symptoms, and I feel well. I am interested in strategies to help me continue to feel well or even better.
- ☐ After my specific problem has been relieved and I understand methods of ensuring it does not return, I am interested in strategies to improve my general health, including regular massage therapy treatments.
- ☐ I have a specific problem and require help with this problem only.

CURRENT HEALTH CONDITION

What brings you in to see us?	
When did it start?	Have you had a similar problem in the past? ☐ Yes ☐ No
The condition is: ☐ constant ☐ comes & goes ☐ getting worse	The condition is interfering with: ☐ work ☐ sleep ☐ daily routine ☐ sports
Have you consulted others regarding this condition? ☐ chiropractor ☐ massage therapist ☐ physiotherapist	How long has it been since you've felt really well?
What makes your condition: Worse? _____ Better? _____	
Please list any major illnesses and surgeries:	
Have you ever been in a car accident, and if yes, when? ☐ Yes When?	
Please list any other health complaints:	

RELEVANT HEALTH HISTORY

HEALTH CARE CENTER

Do you smoke? ☐ Yes ☐ No	Do you sleep on your ☐ back ☐ side ☐ stomach?	Do you sleep well? ☐ Yes ☐ No
What exercises do you do?	What current medications or natural supplements do you take?	What conditions do these medications treat?

Would you like a silent massage?	Are you allergic to any oils/lotions/aromatherapy?	What kind of pressure do you like? ☐ very deep ☐ deep ☐ medium ☐ light ☐ not sure	Are you pregnant? ☐ Yes ☐ No Due date: _____

Please check the conditions you are experiencing now or have experienced in the past:

MUSCLE PAIN AND TENSION

NECK	SHOULDER	ARM	LEG	BACK
☐ right ☐ left ☐ front ☐ back	☐ right ☐ left ☐ front ☐ back	☐ right ☐ left ☐ front ☐ back	☐ right ☐ left ☐ front ☐ back	☐ right ☐ left ☐ front ☐ back

GENERAL	RESPIRATORY	CARDIOVASCULAR	SKIN
☐ allergies ☐ convulsions ☐ dizziness ☐ fatigue ☐ headaches ☐ fibromyalgia ☐ chronic fatigue syndrome	☐ chronic cough ☐ shortness of breath ☐ bronchitis ☐ asthma ☐ emphysema	☐ high/low blood pressure ☐ chronic congestive heart failure ☐ heart disease/attack ☐ phlebitis ☐ stroke/CVA ☐ pacemaker	☐ rash ☐ sensitive ☐ eczema ☐ bruise easily ☐ varicose veins ☐ psoriasis

HEAD/NECK	WOMEN	MEN	COMMUNICABLE DISEASES
☐ ear problems ☐ vertigo ☐ blurred vision ☐ earaches ☐ vision loss ☐ sinus problems	☐ menstrual problems ☐ menopausal problems	☐ prostate cancer ☐ testicular cancer	☐ tuberculosis (TB) ☐ hepatitis ☐ HIV

OTHER CONDITIONS

☐ cancer ☐ arthritis (OA) ☐ arthritis (RA)	☐ epilepsy ☐ hemophilia ☐ diabetes – Onset: _____	☐ internal pins/wires ☐ artificial joints ☐ disc degeneration

DO YOU EXPERIENCE ANY OF THE FOLLOWING SYMPTOMS?

☐ dizziness/fainting/tiredness/fatigue	☐ pain that wakes you at night	☐ allergic reactions

Has it been more than 6 months since your last massage? ☐ Yes ☐ No	What are your favorite parts of a massage? (i.e., feet, shoulders)

I understand and agree that the following information on this form is accurate, current and will be confidential. (Please feel free to adjust the depth/techniques of the massage treatment at any time by telling the therapist your preferences.)

YOU ARE ALWAYS IN COMPLETE CONTROL OF THE TREATMENT.

Signature *Date*