

Informed Consent to Treatment

Please read and fill out the case history carefully and completely to ensure your safety in treatment.

If your health status changes, please inform us immediately. All information gathered is confidential as required by law. You will be asked to provide written authorization for release of any part of your file.

Massage Therapy involves the manipulation of the soft tissues of the body, skin, muscle, ligaments and connective tissues, using therapeutic techniques to produce therapeutic results.

With Massage Therapy, the client disrobes to their comfort level, and lies on a table between two sheets. Only the areas of the body being directly treated are uncovered at any time. Usually the therapist will treat the back, back of the legs, front of the legs, arms and neck. All areas are only treated with consent from the client.

If at any time you are uncomfortable with the pressure or technique being used, you should tell the therapist (i.e. to decrease or increase the pressure, etc.)

You can stop the treatment at any time.

I am aware that this office is keeping personal information provided herein, and that the staff of this office may access this information. I am aware that my file may be viewed by a Quality assurance officer of the College of Massage Therapists of Ontario and will be treated with confidentiality.

I have read the above and give my consent for treatment.

Name (please print) _____

signature _____

Case History

Name _____ Birthdate ____/____/____ (D/M/Y)
 Address _____
 Postal Code _____ Home phone _____
 Work phone _____ Occupation _____
 Family doctor _____ Phone _____
 Chiropractor _____ Phone _____
 May we contact them? _____
 How did you hear about our clinic? _____

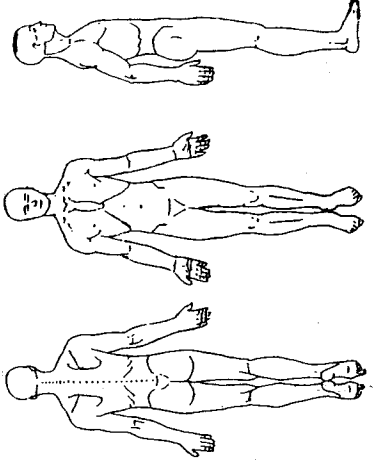
Health History: please indicate conditions you are experiencing or have experienced.

- | | |
|-------------------------|---------------------|
| Bronchitis | headaches |
| shortness of breath | diabetes |
| asthma | allergies |
| sight loss | cancer |
| hearing loss | skin conditions |
| emphysema | contagious diseases |
| high/low blood pressure | TB |
| heart attack/ disease | HIV |
| stroke/ CVA | phlebitis |

Are you pregnant? If yes, what is your due date? _____

Current medication _____
 Previous surgeries _____
 Previous injuries (date and nature) _____

Other medical conditions or areas we should take note of (i.e. digestive disorders, pins, prosthesis) _____



Main complaint

Location of the pain. Please use the diagrams above and try to be as specific as you can. _____
 Cause of pain: _____
 Does the pain radiate to other areas? _____
 How long have you had this pain? _____
 How frequent is the pain (all day / night/ only at certain times?) _____

How intense is the pain? (Scale of 1-- 10) _____
 How would you describe the pain? (achey, burning, throbbing, etc.) _____

What increases the pain? _____
 Decreases the pain? _____
 Are you taking any medications for this condition (muscle relaxants, anti-inflammatory, etc.)? _____
 Have you received or are you receiving any treatment for this condition? If yes, please describe and comment on the success. _____

An accurate health history is necessary to ensure safety in treatment. Please notify us immediately should your health status change. All information gathered is confidential, and is the minimum required by law. You will be asked to provide written authorization for release of any part of your file.

24 hours notice is required for cancellation of an appointment to avoid charges for the missed appointment.

Signature: _____