CONSENT TO TREATMENT FORM

I, ______________________________, of my own free will, consent to be treated for the
Patient Name
following complaint(s):

I acknowledge that I have been provided with sufficient information relevant to the treatment for the above-listed complaint(s)

Alternative courses of treatment where applicable and relevant as well as the possible risks and side effects of the proposed treatment plan, have been explained to me.

I understand fully these possible risks and/or side effects as well as the consequences of having treatment/not having treatment.

I understand that I may stop treatment at anytime(withdraw this consent).

In compliance with the "Consent to Treatment Act" and College of Massage Therapists' Code of Ethics, I provide my full, voluntary, informed consent to be treated by

____

Patients signature: ______________________________

Date: ____________________

Guardian's signature (if patient under age 18): ____________________

Date: ____________________

HEALTH HISTORY FORM

For your information: An accurate health history is important to ensure that it is safe for you to receive a massage treatment. If your health status changes in the future, please let me know. All information gathered for this treatment is confidential except as required or allowed by law or except to facilitate diagnosis (assessment) or treatment. You will be asked to provide written authorization for release of any information.

Name: ______________________ Today's Date: ______________

Address: ______________________ Town: ______________ P.C. ______________

Home Phone #: ______________ Cell #: ______________ Work #: ______________

Date of Birth: ______________ Email: ______________________

Occupation: ______________________ Primary Complaint: ______________________

Referred By: ______________________ Have you received massage therapy before? ☐ Yes ☐ No

Please indicate conditions you are experiencing or have experienced:

Cardiovascular

- ☐ high blood pressure
- ☐ low blood pressure
- ☐ chronic congestive heart failure
- ☐ heart attack
- ☐ phlebitis / varicose veins
- ☐ stroke/CVA
- ☐ pacemaker or similar device
- ☐ heart disease

is there a family history of any of the above? ☐ Yes ☐ No

Respiratory

- ☐ chronic cough
- ☐ shortness of breath
- ☐ bronchitis
- ☐ asthma
- ☐ emphysema

is there a family history of any of the above? ☐ Yes ☐ No

Infections

- ☐ hepatitis
- ☐ skin conditions
- ☐ TB
- ☐ HIV
- ☐ herpes

Other Conditions

- ☐ loss of sensation, where? ______________
- ☐ diabetes, onset: ______________
- ☐ allergies/hypersensitivity to what? ______________

  type of reaction: ______________
- ☐ epilepsy
- ☐ cancer, where? ______________
- ☐ skin conditions, what? ______________
- ☐ arthritis

is there a family history of arthritis? ☐ Yes ☐ No

Head/Neck

- ☐ history of headaches
- ☐ history of migraines
- ☐ vision problems
- ☐ vision loss
- ☐ ear problems
- ☐ hearing loss

Women

- ☐ pregnant, due: ______________
- ☐ gynaecological conditions, what? ______________

Overall, how is your general health? ______________

Primary Care Physician: ______________

Address: ______________

____

Current Medications: ______________

condition it treats: ______________

____

Are you currently receiving treatment from another health care professional? ☐ Yes ☐ No

If yes, for what? ______________

____

Surgery – date ______________

nature: ______________

Injury – date ______________

nature: ______________

Do you have any other medical conditions? (e.g. digestive conditions, haemophilia, osteoporosis, mental illness) ☐ Yes ☐ No

what? ______________

Do you have any internal pins, wires, artificial joints or special equipment ? ☐ Yes ☐ No

what? ______________

where? ______________

What is the reason you are seeking massage therapy? Please include the location of any tissue or joint discomfort.

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Notes:

Date of initial Health History: ______________
Update 1 ______________
Update 2 ______________
Update 3 ______________
Update 4 ______________