Registered Massage Therapists' Association of Ontario

Consent to Participate

Please be advised that payment in full is due on the day of treatment. For your convenience, payment may be made via cash, debit and credit card.

CANCELLATION POLICY:

We understand that you may need to cancel an appointment. Should you need to cancel your scheduled appointment, you must notify the clinic via phone or email ***at least 24 hours in advance.*** If you fail to notify the clinic within 24 hours, a cancellation fee equivalent to 50% of the cost of the scheduled appointment will be applied. This fee will be applied at the discretion of the therapist.

FAILURE TO ATTEND:

Failure to show up for your allotted appointment time will result in a charge equivalent to the full price of the scheduled appointment. The fee will be waived for the first incident. Additional occurrences will result in a cancellation fee, applied at the discretion of the therapist.

PRIVACY POLICY:

In order to provide treatment, this clinic must collect some personal health information. The privacy policy is posted in the waiting area.

Acknowledgment and Consent

I, _____, acknowledge that I have read and understand the policies set out above. I understand that I will be participating in massage treatment, which has been explained to me by my Registered Massage Therapist and hereby consent to treatment. My Registered Massage Therapist has explained what is meant by informed consent and I understand that I may withdraw my consent to treatment at any time. I understand and accept the risks involved in massage therapy as explained by my therapist.

I consent to accurately provide information about my health to my therapist to help my therapist provide the best treatment.

I understand the privacy policy of this clinic.

Signed this _____ day of _____, 20_____

_____

_____ _____

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Health History

The information request below will assist us in treating you safely. Feel free to ask any questions about the information being requested. Please note that all information provided below will be kept confidential unless allowed of required by law. Your written permission will be required to release any information			
Name:		Date of Birth:	
Address:			
City:		Province:	Postal Code:
Home Phone:	Work Phone:	Cell Phone:	
Email:		Preferred Method of Contact:	
Occupation:			
Have you received massage therapy before? ☐ Yes ☐ No			
Did a health care practitioner refer you for massage therapy? ☐ Yes ☐ No			
If yes, please provide their name and phone number:			
Family physician name and phone number:			
Have you received treatment from another health care professional in the past year? ☐ Yes ☐ No			
If yes, please provide type of treatment (chiropractic, physiotherapy, etc):			
Emergency Contact:		Phone:	
Do you have extended health care benefits? ☐ Yes ☐ No If yes, company name:			
Primary Complaint:			
Injuries:		Date of occurrence:	
Were these injuries sustained as a result of a motor vehicle accident? ☐ Yes ☐ No			
Were these injuries sustained at work? ☐ Yes ☐ No			
Please list all surgeries and dates:			
Please list all current medications and conditions they are treating:			

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Please indicate conditions you are experiencing or have experienced:

Cardiovascular:
☐ High Blood Pressure
☐ Low Blood Pressure
☐ Chronic Congestive Heart Failure
☐ Heart Attack
☐ Heart Disease
☐ Heart Palpations
☐ Heart Murmur
☐ Stroke / CVA
☐ Aneurism
☐ Angina
☐ Blood Clots
☐ Raynaud's Disease
☐ Phlebitis / Varicose Veins
☐ Poor Circulation
☐ Pacemaker or Similar Device

Respiratory:
☐ Chronic Cough
☐ Shortness of Breath
☐ Bronchitis
☐ Asthma
☐ Emphysema
☐ Pneumonia
☐ Tuberculosis
☐ Sinusitis
☐ Sinus Congestion
Do you smoke? ☐ Yes ☐ No

Blood:
☐ Anaemia
☐ Haemophilia
☐ Leukemia
☐ Hepatitis A B C

Lifestyle:
Regular Exercise
☐ Yes ☐ Mostly ☐ No
Drink Plenty of Water
☐ Yes ☐ Mostly ☐ No
8 Hours of Sleep Nightly
☐ Yes ☐ Mostly ☐ No
Good Eating Habits
☐ Yes ☐ Mostly ☐ No

Gastrointestinal:
☐ Constipation
☐ Diarrhea
☐ Gas / Bloating
☐ Nausea / Vomiting
☐ Irritable Bowel Syndrome
☐ Crohn's / Colitis
☐ Hernia
☐ Ulcers
☐ Gall Bladder Problems
☐ Liver Problems
☐ Kidney Infections
☐ Bladder Infections
☐ Urination Problems
☐ Poor Appetite
☐ Excessive Thirst

Skin:
☐ Allergies:
☐ Hypersensitivity
☐ Bruises Easily
☐ Rashes
☐ Eczema
☐ Psoriasis
☐ Athletes Foot
☐ Herpes
☐ Warts
☐ Skin Conditions:

Women:
☐ Pregnant, Due:
☐ Infertility
☐ Menstrual Concerns / Pain
☐ Menopausal Concerns
☐ Endometriosis
☐ Fibroids
☐ Hysterectomy
☐ Vaginal Pain / Infection

General Health:
☐ Good ☐ Fair ☐ Poor

Other (please list):

Head / Neck:
☐ Headaches
☐ Migraines
☐ Whiplash
☐ Jaw Pain
☐ Ear Pain
☐ Hearing Problems
☐ Hearing Loss
☐ Vision Problems
☐ Vision Loss

Muscle / Joint:
☐ Muscle Strain
☐ Ligament Sprain
☐ Spasms / Cramps
☐ Tendinitis
☐ Bursitis
☐ Fibromyalgia
☐ Ankylosing Spondylitis
☐ Arthritis OA RA
☐ Osteoporosis
☐ Herniated Disc
☐ Degenerative Discs
☐ Joint or Bone Disease
☐ Scoliosis
☐ Dislocation
☐ Fracture

Other Conditions:
☐ Diabetes, onset:
☐ HIV / AIDS
☐ Cancer
Type?
☐ Multiple Sclerosis
☐ Epilepsy
☐ Thyroid Disorders
☐ Lupus
☐ Loss of Sensation
Where?
☐ Insomnia / Fatigue
☐ Fainting / Dizziness
☐ Anxiety / Nervousness
☐ Depression
☐ Alcohol / Drug Addiction

Is there a family history of any of the conditions listed above?
Do you have any internal pins, wires, artificial joints or special equipment? ☐ Yes ☐ No
If yes, where?

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Please ensure you read the following information in its entirety.

I have read the above information and have stated all my previous and current medical conditions. I will update the Registered Massage Therapist regarding any updates in my condition as soon as possible.

In order to provide treatment, this clinic must collect personal health information. I understand that all information that I provide will be kept confidential unless allowed or required by law. I understand that I will be asked for written authorization before this information can be released.

I understand the 24 hour cancellation policy and agree to pay the missed appointment fee if I cancel within the 24 hour period preceding my appointment time. I understand that I am responsible to pay for the time reserved with the Registered Massage Therapist; regardless of the time I arrive and am ready for my appointment. I understand that this time will include intake, assessment, treatment, self-care recommendations, charting and administration. I understand that payment in full is due on the day of treatment.

Signature:_____ Date: _____

Permission to verify information on issued receipt with patient's insurer? Yes ☐ NO☐

Chart for Registered Massage Therapist's Use Only