DOUGLASDALE FAMILY CHIROPRACTIC

Massage Therapy Form

Today's Date: _____

Name: _____

Address: _____ Postal Code: _____

Phone (Home): _____ (Cell): _____

Date of Birth: _____ Occupation: _____

Email: _____ How did you hear about us? _____

Allergies: _____

_____

Current Medications including over the counter and supplements: _____

_____

Family Doctor: _____ Phone: _____

Emergency Contact: _____ Phone: _____

Have you received a professional Massage Treatment before? **Yes** **No**

Have you dealt with any of the following in the **last 6 months**? **Y**: Yes **N**: No

Musculosketetal
Bone or Joint Disease ____
Tendonitis ____
Bursitis____
Broken/fractured bones ____
Osteoarthritis____
Rheumatoid arthritis ____
Neck/ whiplash____
Shoulder/arm injury ____
Back/hip/leg injury ____
Osteoporosis ____

Jaw/TMJ or ear pain____
Headaches or migraine/ head injuries ____
Spasms/Cramps ____

Respiratory
Chronic cough ____
Chest pain ____
Asthma/Allergies____
Difficulty breathing ____

Other
Cancer/Tumors____
Fibromyalgia____
Epilepsy ____
Nervous disorders ____
Crohn's disease ____
Pelvic inflammatory disease ____
Diabetes ____

Skin
Dryness____
Bruise easily ____
Allergies____
Rashes____
Athletes foot _
Warts____
Psoriasis____
Eczema ____

Circulatory
Heart Condition____
Varicose Veins____
Lymphedema ____

High/low blood pressure____
Fainting or dizziness ____
Phlebitis ____

Mental Health Condition ____
Poor nutrition ____
Drug Consumption ____
Nicotine ____
Caffeine ____
Alcohol Consumption ____

Digestive
Constipation____
Diarrhea____
Gas/Bloating____
Diverticulitis ____
I.B.S. ____

Nervous System
Numbness/Tingling____
Fatigue ____

Chronic pain ____
Herpes/ Shingles ____
Sleep Disorder ____

Genito-Urinary
Pregnant____if current # of weeks ____
PMS ___
Menopause ____
kidney disease ____
Frequent/painful urination ____
Prostate trouble ____

Family Health History (relationship)
Migraines_____
Arthritis_____
Heart Disease _____
Strokes_____
Diabetes_____
Cancer _____

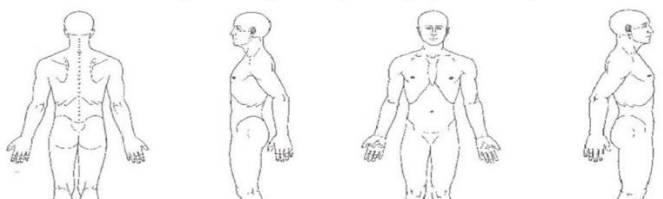
Did the current injury result from a motor vehicle accident or workplace injury? **Y** **N**
Do you see a chiropractor/ physiotherapist? **Y** **N**
Have you had surgery in the past? **Y** **N** If yes, when and for what? _____

_____

Reason/goals for this treatment: _____
Are you in Pain? **Y** **N** When did it begin?: _____ Location of pain: _____

- **Please circle areas of pain**
- **Draw an "X" over areas of stiffness**
- **Draw squiggly lines over areas of numbness, tingling or altered sensations**

Explain, if necessary: _____



INFORMED CONSENT TO MASSAGE THERAPY TREATMENT

I understand that the massage therapist is providing massage therapy services within their scope of practice as defined by their professional membership. I acknowledge that the therapist is not a physician and does not diagnose illness or disease or any other physical or mental disorder. I clearly understand that massage therapy is not a substitute for a medical examination. It is recommended that I attend my personal physician for any ailments that I may be experiencing. I acknowledge that no assurance or guarantee has been provided to me as to the results of the treatment. I acknowledge that with any treatment there can be risks and those risks have been explained to me and I assume those risks.

I acknowledge and understand that the therapist must be fully aware of my existing medical conditions. I have completed my medical history form as provided by my therapist and disclosed to the therapist all of those medical conditions affecting me. It is my responsibility to keep the massage therapist updated on my medical history. The information I have provided is true and complete to the best of my knowledge.

I hereby consent for my therapist to treat me with massage therapy for the above noted purposes including such assessments, examinations and techniques, which may be recommended, by my therapist.

I authorize my therapist to release or obtain information pertaining to my condition(s) and/or treatment to/from my other caregivers or third party payers.

I have read the above noted consent and I have had the opportunity to question the contents and my therapy. By signing this form, I confirm my consent to treatment and intend this consent to cover the treatment discussed with me and such additional treatment as proposed by my therapist from time to time, to deal with my physical condition and for which I have sought treatment. I understand that draping will be used during the session, and only the area being worked on will be uncovered. At any time I may withdraw my consent and treatment will be stopped.

Clients under the age of 18 years must be accompanied by a parent/guardian during the entire session unless waived by the parent/guardian.

Massage Therapy Cancellation Policy

We require 24 hours' notice for cancellation of massage appointments

If less than 24 hours' notice is given, we reserve the right to charge the following:

1st time: 50% of the appointment cost

2nd time: 100$ of the appointment cost

For no-show appointments, you will be charged 100%

Patient Name:_____Signature of Parent/Guardian: _____

As parent/guardian, I agree not to be present during session (Initial) _____

Witness:_____Date Signed: _____