Oakville Chiropractic Centre

Health History Section:

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 provide below will be kept confidentially unless allowed or required by law. Your written permission will be required to release any information.

Name: ______________________ Date of Birth (dd/mm/yyyy): ______________________
Address: ______________________ City: ______________________
Postal Code: ______________________ Home Phone: ______________________
Cell Phone: ______________________ Work Phone: ______________________
Email: ______________________ Referral Method: ______________________
Occupation: ______________________ Have you ever received massage therapy before? ❑ Yes ❑ No
Did a healthcare practitioner refer you for massage therapy? ❑ Yes ❑ No
If yes, please provide their name and address: ______________________
____

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? ______________________
- ❑ allergies / hypersensitive to what? ______________________
- ❑ 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 date: ______________________
gynaecological conditions, what? ______________________

Overall, how is your general health? ______________________
Primary Care Physician: ______________________
Address: ______________________
____

Current Medications: ______________________
Conditions it treats: ______________________
Are you currently receiving treatment from another health care professional?
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)?
____

Notes:

Date of Initial Health History: ______________________

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General Liability Release Form:

By signing below, you agree to the following:

1. I give my permission to receive massage therapy.
2. I understand that therapeutic massage is not a substitute for traditional medical treatment or medications.
3. I understand that the massage therapist does not diagnose illnesses or injuries, or prescribe medications.
4. I have clearance from my physician to receive massage therapy (if needed).
5. I understand the risks associated with massage therapy include but are not limited to:
   - Superficial bruising
   - Short-term muscle soreness
   - Exacerbation of undiscovered injury
   I therefore release the company and the individual massage therapist from all liability concerning these injuries that may occur during the massage session.
6. I understand the importance of informing my massage therapist of all medical conditions and medications I am taking, and to let the massage therapist know about any changes to these. I understand that there may be additional risks based on my physical condition.
7. I understand that it is my responsibility to inform my massage therapist of any discomfort I may feel during the massage session so he/she may adjust accordingly. Note: we encourage you to speak up.
8. I understand that I or the massage therapist may terminate the session at any time.
9. I have been given the chance to ask questions about the massage therapy session and my questions have been answered.

Signature: ______________________ Date: ______________________

Informed Consent of Massage Therapy Fees:

Your scheduled length of appointment includes changing and consultation time. Fees, procedures and policies are listed below. By signing the below, you agree to the following:

1. Proper draping procedures will be used at all times. Only the area being worked on will be undraped at any one time. The client will disrobe in private. The client may choose to remove or leave on clothing according to individual comfort levels.
2. The client always has the right to modify, terminate or refuse treatment at any time regardless of prior given consent.
3. Client records are confidential and will not be released without the client's written consent.
4. If the client has questions about any aspect of massage therapy, or specifics concerning their treatment, they may ask their massage therapist at any time.
5. Treatment fees are as follows:
   30 minute massage - $50 + HST = $56.50 45 minute massage - $70 + HST = $79.10
   60 minute massage - $90 + HST = $101.70 90 minute massage - $120 + HST = $135.60
   75 minute hot stone massage - $140 + HST = $158.20
6. The Oakville Chiropractic Centre has a **24 HOUR CANCELLATION POLICY** for massage therapy appointments. If I miss or cancel an appointment with less than 24 hours' notice **I agree to pay the cancellation fee** as set by the Oakville Chiropractic Centre.

I have read and understand the above information and am making an informed choice to consent to treatment:

Signature: ______________________ Date: ______________________

Name (Please print): ______________________ RMT Verification: ______________________

Oakville Chiropractic Centre

Consent for Assessment and Treatment of Sensitive Areas:

I, ________________________________ (name), have requested assessment and/or treatment by this Registered Massage Therapist (RMT) _________________________ (name) for treatment of the clinically relevant areas indicated below (please initial):

___Buttocks (gluteal muscles) ___Chest Wall Muscles ___Upper Inner Thigh(s) ___Breast(s)

The RMT has explained the following to me and I fully understand the proposed assessment and/or treatment:

- The nature of the assessment, including the clinical reason(s) for assessment of the above area(s) and the draping methods to be used
- The expected benefits of the assessment
- The potential risks of the assessment
- The potential side effects of the assessment
- That consent is voluntary
- That I can withdraw or alter my consent at any time.

I voluntarily give my informed consent for the assessment and/or treatment as discussed and outlined above.

____

Client Name (print):

________________________________ ________________________________

Signature: Date:

Ongoing Treatment:

I am aware that the treatment of the above indicated area(s) is part of a treatment plan which has been discussed with me by my RMT. I confirm that, on the following date(s), the RMT has reviewed the treatment plan and I provide my informed consent.

________________________________ ________________________________

Signature: Date:

________________________________ ________________________________

Signature: Date: