Health History Form

Amy Beitel Massage Therapy

Avonlea, Sk

Name: _____ **Date:**_____

Address: _____ **Phone #**_____

City: _____ **Postal Code:** _____ **Work #**_____

DOB: _____ / _____ / _____ **Cell #** _____

DD/MM/YYYY

E-mail Address: _____

Occupation: _____ **Emergency Contact:** _____

Referred By: _____ **Emergency Contact: Ph#:** _____

Doctor's Name: _____ **Dr. Phone #:** _____

Allergies: _____

Sports & activities: _____

Current medications: _____

_____

Are you under medical care for any of the following: (circle)

Heart Conditions	Varicose Veins	Neck Injury
Osteoporosis	Cancer	Diabetes
Crohn's Disease	Nervous Disorders	High/Low blood pressure
Back Injury	Rheumatoid Arthritis	Phlebitis/Circulatory problems
Kidney Disease	Asthma/Respiratory	Pelvic Inflammatory Disease
Whiplash	Fainting or Dizziness	Headaches or Migraine
Jaw or Ear pain	Osteoarthritis	Skin conditions
Fibromyalgia	Epilepsy	Other:

Have you received care from any of the following: (circle)

Physiotherapist	Chiropractor	Massage Therapist
Naturopath	Acupuncture	Other: _____

Reason for today's treatment: _____

Have you had surgery in the past? For what? _____

Have you had any fractures/sprains in the past? Where? _____

Have you had any serious illnesses in the past? What? _____

What relieves your pain? _____

What aggravates your pain? _____

Signature of Client or Guardian: _____

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 the Massage Therapist Association of Saskatchewan, Inc.

I hereby consent to 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 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 aliments 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 authorize my Therapist to release or obtain information pertaining to my condition(s) and/or treatment to/from my other care givers or third party payers.

I have read the noted consent and 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 this 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 at any time I may withdraw my consent and treatment will be stopped.

During massage treatments it is important that you communicate your level of comfort with your Therapist at all times. It is common to experience an increased tenderness, pain and/or bruising with massage treatments.

**If you are having a cupping massage treatment, please be advised of the following additions to the above consent; tenderness, light to deep red marking/bruises, blistering (rare but can occur) will occur where the cups are placed. **

CUPPING CONSENT – PLEASE INITIAL HERE: _____

CANCELLATION POLICY

If you are unable to hold your scheduled appointment please provide me with 24 hours notice. If a minimum of 6 hours notice is not received to reschedule or cancel your appointment you will be charged the full treatment cost, to be paid before scheduling your next appointment.

_____ _____

Patient Name (please print) Patient/Guardian Signature

_____ _____

Witness Date