Massage Therapy Health History Form Date of Initial Visit: _____

An accurate health history is important to ensure that it is safe for you to receive a massage therapy treatment. If your health status changes, let your massage therapist know as soon as possible and this form will be updated. All information gathered for this treatment is confidential and will only be used to facilitate a diagnosis (assessment), and treatment. You will be asked to provide written authorization for release of any information. (Please Print)

Name: _____ Date of Birth (mm/dd/yyyy): _____

Address: _____ City: _____ Postal Code: _____

Home Phone: _____ Work: _____ Cell: _____

Sask. Hosp # _____ Referred by: _____

Email_____ Occupation: _____

Family Physician _____ Allergies: _____

Sports & Activities _____

Current medications_____

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

Heart conditions	High/Low Blood pressure	Fainting or dizziness	Headaches or migraine
Varicose veins	Phlebitis/Circulatory problems	Back Injury	Jaw or ear pain
Neck Injury	Osteoporosis	Rheumatoid Arthritis	Osteoarthritis
Cancer	Kidney disease	Skin conditions	Nervous disorders
Diabetes	Asthma/Respiratory issues	Fibromyalgia	Hepatitis
Crohn's Disease	Pelvic inflammatory disease	Epilepsy	HIV/Aids
Whiplash	Bruise easily	Other:	

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

Physiotherapist Chiropractor Massage Therapist Naturopath

Other: _____

Reason for treatment: _____

When did you first notice the symptoms? _____

Have you had surgery in the past? Yes _____ No _____ If yes, for what? _____

Have you had any fractures/sprains in the past? Yes ___ No ___ If yes, where? _____

Have you had any serious illnesses in the past? Yes ___ No ___ If yes, what? _____

Did the current injury result from a motor vehicle accident or workplace injury? Yes _____ No _____

Have you had any of the following regarding your current condition? (circle)

Physician's examination X-ray Other diagnostic test(s)

What relieves your pain? _____

What aggravates your pain? _____

Signature of Patient (or Guardian): _____ Date: _____

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 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 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 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 health history form as provided by my therapist and disclosed 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.

During the 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.

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 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 at any tome I may withdraw my consent and treatment will be stopped.

I HAVE READ, UNDERSTOOD, and AGREE to the above consent.

Patient Name (Please Print): _____ Date: _____

Signature of Patient (Guardian if under 18): _____ Date: _____

MISSED APPOINTMENT / CANCELLATION POLICY

Your appointment time is reserved specifically for you. If you are unable to keep your time, we kindly as that you give the clinic a minimum 24-hour advance notice in order for the clinic to give the therapist a reasonable amount of time to fill the appointment slot.

Because our therapists get affected directly when appointments are missed, or when appointments are cancelled with less than 24-hour notice, you will be charged the full price of the time booked if no notice is given. This amount must be paid prior to your next schedules appointment.

If you arrive late, your session may be shortened in order to accommodate others whose appointments follow yours. Depending on how late you arrive, your therapist will then determine if there is enough time remaining to start a treatment. Regardless of the length of treatment actually given, you will be responsible to pay for the full session booked.

I HAVE READ, UNDERSTOOD, and AGREE to the above policy.

Signature of Patient (Guardian if under 18): _____ Date: _____

Witness: _____ Date: _____

Fragrance Free Environment

Please refrain from wearing lotions, after shaves, perfumes, hair sprays or other products are scented