WOODSTOCK MASSAGE THERAPY

The information requested below will assist us in treating you safely. Feel free to ask any questions about the information being collected. Please note that all information provided will be kept confidential unless allowed or requested by law. Your written permission will be required to release any information. Please inform us of any changes to your health status/medications, etc.

NAME: _____ EMAIL: _____

DATE OF BIRTH: _____ PHONE: _____

ADDRESS: _____ CITY: _____ POSTAL CODE: _____

OCCUPATION: _____ PRIMARY COMPLAINT: _____

HOW DID YOU HEAR ABOUT US?

□ GOOGLE □ FACEBOOK/INSTAGRAM

□ CURRENT CLIENT _____ □ OTHER_____

HISTORY OF MASSAGE: _____ GENERAL HEALTH STATUS: _____

EMERGENCY CONTACT: _____ EMERGENCY PHONE: _____

PHYSICIAN'S NAME: _____ ADDRESS: _____ PHONE: _____

WOULD YOU LIKE TO RECEIVE OUR MONTHLY NEWSLETTER? □ YES PLEASE □ NO THANKS

**Please indicate any conditions you are currently experiencing, or have in the past:**

**Emotion & Memory**
□ Alzheimer Disease
□ Anxiety Disorder
□ Mood Disorder
□ Schizophrenia
□ Stress

**Oncology**
Cancer Type
_____
Date of Diagnosis
_____
Location
_____
Treatment(s)
_____
_____
Side Effects
_____
_____
Status
_____
□ Lymph Node Removal (where) _____
□ Current Tumor (where) _____
□ Fragile Skin
□ Lymphedema
□ Medical Devices
□ Radioactivity

**Prenatal**
Due Date _____
□ Swelling/Edema
□ Leg Cramps
□ Pre-Eclampsia
□ Sciatica
□ Separation of Rectus Muscle
□ Separation of Pubic Symphysis
□ High Risk Pregnancy

**TMJ/Jaw**
□ Clenching
□ Clicking
□ Difficulty chewing
□ Difficulty opening jaw
□ Jaw Pain
□ Locking

**Headaches**
□ Chronic Daily Headaches
□ Cluster
□ Headaches
□ Migraines
□ Rebound
□ Sinus
□ Tension

**Blood**
□ Hemophilia
□ Hepatitis
□ HIV/AIDS
□ Thrombosis or Embolism

**Cardiovascular**
□ Blood Clots
□ Cardiovascular Accident
□ Chronic Venous Insufficiency
□ Congestive Heart Failure
□ Heart Attack
□ Heart Disease
□ High Blood Pressure
□ Low Blood Pressure
□ Lymphedema
□ Pacemaker
□ Phlebitis
□ Raynaud's Disease
□ Varicose Veins

**Endocrine**
□ Acute Pancreatitis
□ Diabetes
□ Hyperthyroidism
□ Hypothyroidism

**Family History**
□ Arthritis
□ Cardiovascular Cond.
□ Respiratory Cond.

**Hearing**
□ Ear Problems
□ Hearing Loss
□ Meniere Disease
□ Tinnitus
□ Vertigo

**Immune**
□ Allergies _____
□ Anaphylaxis
□ Infectious Mononucleosis
□ Lupus
□ Rheumatoid Arthritis

**Musculoskeletal**
□ Ankylosing Spondylitis
□ Arthritis
□ Artificial Joints or Special Equipment _____
□ Chronic Fatigue Syndrome
□ Chronic Myofascial Pain
□ Dislocation _____
□ Fibromyalgia
□ Fracture
□ Joint Injury _____
□ Muscular Dystrophy
□ Osteoarthritis
□ Osteoporosis
□ Scoliosis
□ Sinus Problems
□ Strain/Sprain _____
□ Tendonitis/Bursitis

**Neurological**
□ Brain Injury
□ Cerebral Palsy
□ Cerebral Vascular Accident
□ Chronic Pain Disorder
□ Epilepsy
□ Herniated Disk
□ Loss of Sensation (where) _____
□ Multiple Sclerosis
□ Parkinson's

□ Sciatic Pain
□ Stroke
□ Tingling (where)
_____
□ Transient Ischemic Attacks (TIA)
□ Vertebral or Spinal Cord Injury

**Reproductive**
□ Endometriosis
□ Gynecological Conditions
□ Ovarian Cysts/Tumors

**Respiratory**
□ Asthma
□ Bronchitis
□ Chronic Cough
□ COPD
□ Cystic Fibrosis
□ Emphysema
□ Infectious Respiratory Conditions
□ Shortness of Breath

**Skin**
□ Allergic Dermatitis
□ Athlete's Foot
□ Bruise Easily
□ Herpes
□ Infectious Skin Condition
□ Melanoma/Carcinoma
□ Plantar's Wart
□ Skin Conditions

**Miscellaneous**
□ ADHD
□ Autism
□ Insomnia
□ Mental Illness
□ Surgical Pins or Wires
□ Vision Loss
□ Vision Problems

OTHER DIAGNOSED DISEASES OR MEDICAL CONDITIONS: _____

CURRENT MEDICATIONS: _____

INJURIES (INCLUDE DATE): _____

SURGERIES (INCLUDE DATE): _____

IS THERE ANYTHING ELSE YOU THINK WE SHOULD KNOW? _____

CANCELLATION POLICY:

Your appointment time is reserved just for you. We require at least **24 hours notice if you need to cancel or reschedule.** Failure to provide adequate notice will result in a missed appointment fee that is equal to the cost of the treatment booked. This amount must be paid in full prior to your next appointment, or within 30 days. This fee **cannot** be billed to your insurance company. If you miss your apt when using a gift certificate, the fee for the missed appointment will be deducted from the gift certificate. Thank you for your cooperation.
I understand this cancellation policy. _____ (initials only)

INFORMED CONSENT:

I offer my consent for the purposes of receiving massage therapy treatment, which includes modalities that fall under the scope of practice for (RMTs) Registered Massage Therapists in Ontario.

**Assessment and treatment of sensitive areas**

The following applies to areas considered sensitive by the CMTO. Treatment of these areas requires written consent. (Common symptoms that could indicate treatment listed below. Clinical indications are provided on the laminated copy)

I have requested the assessment and/or treatment by the Registered Massage Therapists (RMTs) at Woodstock Massage Therapy for treatment of the areas identified below. As part of my therapeutic assessment and massage therapy treatment, I am aware that the RMT will touch the following area(s) of my body (Please INITIAL beside the area(s) which apply to your treatment):

| | | |
|---|---|---|
| _____ | Gluteal muscle(s) (buttocks) | (E.g. Hip pain, sciatic symptoms, low back pain) |
| _____ | Inner thigh(s) | (E.g. Groin pull, lymphatic drainage) |
| _____ | Chest wall muscle(s) | (E.g. Pec strain, lymphatic drainage, chest/rib pain) |
| _____ | Breast tissue | (Individual basis, would be discussed at length with RMT) |

My RMT has explained to me and I fully understand the proposed treatment including: the nature of the assessment, including the clinical reason(s) for treatment and the draping methods to be used, the expected benefits of the treatment, the potential risks and/or side effects of the treatment, alternate courses of action and likely outcomes.

I understand that I may verbally withdraw my consent at any time. I have read and understand the policies of Woodstock Massage Therapy.

_____ _____ _____

(PRINT NAME) (SIGNATURE) (DATE)