KLEINBURG
INTEGRATIVE HEALTH

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MASSAGE THERAPY INTAKE AND MODALITY CONSENT FORM

Your health history information will help us treat you safely. All information you provide is strictly confidential, unless requested by law, and will need your extra written consent for any requested disclosures.

Name: _____ **Date of Birth:** _____ Occupation: _____

Address: _____ City: _____ Postal Code: _____

Home#: _____ Cell# / Work#: _____ Email: _____

Preferred Contact: _____ Emergency Contact Name: _____ Tel#: _____

Family Physician's Name: _____ Address: _____ Tel#: _____

Your General Health is? _____ **Primary Complaint for Massage:** _____

Have you ever had Massage Therapy? **Yes / No** Who Referred you? _____

Please **circle** ○ conditions you are **currently** experiencing, and **checkmark** ☑ conditions **previously** experienced.

Soft Tissue / Joints:
Tendonitis / Bursitis
Weakness
Sprains / Strains / Spasm
Arthritis: OA / RA / Other
Herniated Spinal Disc
Frozen Shoulder / Hip

Skin:
Skin Condition(s):

_____

Bruise Easily
Herpes
Varicose Veins
Athletes Foot
Warts
Plantar Warts
Loss of Sensation

Headaches:
Tension Headache
Migraine
Tooth / Jaw / Ear pain
Head trauma – date:

_____

Respiratory:
Chronic cough
Shortness of Breath
Bronchitis
Asthma
Emphysema
Pneumonia
Sinus Problems

Cardiovascular:

High Blood Pressure

Low Blood Pressure
Heart Attack
Phlebitis
Stroke / CVA
Pacemaker
Heart Disease
Angina
Chronic Congestive Heart Failure

Accident / Injury :

Car Accident
Whiplash
Fractures
Dates: _____

Other Conditions:
Neurological Conditions:

_____

Diabetes – onset: _____

Allergies: _____

anaphylaxis? Yes / No

Epilepsy
Cancer: _____
Vision Problems

Hearing Loss / Tinnitus

Constipation
Other Digestive Issues:

_____

Insomnia
Kidney / Bladder Problems
Haemophilia
Fibromyalgia
Osteoporosis
Surgical Implants (pins, plates, wires)

Infectious Disease:
Hepatitis
Tuberculosis
HIV / AIDS
Other: _____

Women: Pregnant – Due: _____ Gynecological Conditions: _____

Any Other Medical Conditions? _____

Family History of Conditions: _____

Current medications: _____

Conditions it treats: _____

Previous surgeries / injuries: _____

Presence of internal pins, wires, metal plates: _____

Other Healthcare used? Chiropractor / Physiotherapy / Naturopathic / TCM / Other: _____

INFORMED CONSENT FOR TREATMENT

Massage Therapy is the manipulation of soft tissue of the skin, muscles, ligaments, tendons and connective tissues using various techniques and pressures to produce therapeutic results.

With Massage Therapy, the client disrobes to their comfort level and lies on a massage table between two sheets. The registered massage therapist will only drape one body region at a time that will be directly treated. Unscented oil is always used first and essential oils may also be used upon request.

If at any time you are uncomfortable with the oils, pressures or techniques being used during treatment, please tell the therapist as soon as you can so they can modify your treatment for you for your comfort. You may also stop the treatment at any time.

If you require treatment of any clinically sensitive areas (chest wall, breast tissue, gluteus muscles, upper and inner thigh muscles, **please initial** next to the clinically sensitive areas below to include in your treatment plans. You may withdraw consent at any time.

_____ (initial) Gluteus Muscles

_____ (initial) Chest Wall Muscles (pectoral muscles)

_____ (initial) Upper Thigh Muscles (quadriceps and hamstring muscles)

_____ (initial) Inner Thigh Muscles (adductor muscles)

_____ (initial) Breast(s) Tissue

" I _____ *(Print Name)* _____, have read the above give my consent for ALL Registered Massage Therapists working at Kleinburg Integrative Health Clinic to move forward with the proposed treatment plan and include these clinically sensitive areas into my current and ALL treatments. Should I withdraw my consent or need to change my consent, I will let the clinic and R.M.T. know. I understand that I can do this at any time. If I need to change my health history as well, I understand I may do so by letting the clinic or R.M.T. know. I understand that there is a **24 hours cancellation/rescheduling policy**. If I miss a treatment or do not give enough notice, I understand a full treatment fee will be charged.

Signature: _____ Date:_____

Updates: _____ _____ _____ _____