HANDS ON HEALTH
MASSAGE THERAPY CENTRE

We would like to take this opportunity to welcome you to our clinic! The information requested below will assist us in treating you safely. Feel free to ask any questions about the information being requested. Please note that all information provided below will be kept confidential unless allowed/required by law. Your written permission will be required to release any information.

Name: _____DOB: Day____Month_____Year _____

Address: _____Postal Code: _____

Home Phone: _____ Work Phone: _____Cell Phone: _____

Email Address: _____Occupation: _____

Where did you hear about our centre? _____

Name & address of your physician: _____

Do you give us permission to send you additional informational regarding our centre and services? ___Y ___N

Check the following conditions that apply to you, past and present. Please add your comments to clarify the conditions.

Circulatory and Respiratory
□ Dizziness
□ Fainting
□ Cold feet or hands
□ Blood clots
□ Stroke
□ Heart attack
□ Angina
□ Allergies _____
□ Sinus problems
□ Asthma
□ High blood pressure
□ Low blood pressure
□ Lymphedema
□ Other: _____

Musculo-Skeletal
□ Headache
□ Joint stiffness/swelling
□ Spasms/cramps
□ Broken/fractured bone
□ Strains/sprains
□ Back/hip pain
□ Shoulder/neck/arm/hand pain
□ Leg/foot pain
□ Chest/ribs/abdominal pain
□ Problems walking
□ TMJ (jaw) pain
□ Tendonitis
□ Bursitis
□ Arthritis - family history □
□ Osteoporosis
□ Scoliosis
□ Other: _____

Digestive
□ Indigestion
□ Constipation
□ Intestinal gas/bloating
□ Diarrhea
□ Irritable bowel syndrome
□ Crohn's Disease
□ Colitis
□ Adaptive aids
□ Other: _____

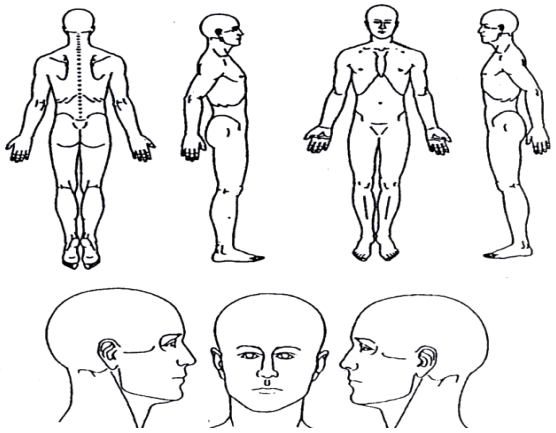
Nervous System
□ Numbness/tingling
□ Twitching of face
□ Fatigue
□ Chronic pain
□ Sleep disorders
□ Ulcers
□ Paralysis
□ Herpes/shingles
□ Cerebral Palsy
□ Epilepsy
□ Chronic Fatigue Syndrome
□ Multiple Sclerosis
□ Muscular Dystrophy
□ Parkinson's
□ Spinal cord injury
□ Other: _____

Reproductive System
□ Children
□ Menopause
□ Hysterectomy
□ Fertility concerns
□ Prostate disorder
□ Other: _____

Skin
□ Rashes
□ Allergies: _____
□ Athlete's foot
□ Warts
□ Moles
□ Cosmetic surgery
□ Other: _____

Other
□ STD: _____
□ Forgetfulness
□ Confusion
□ Depression
□ Difficulty concentrating
□ Drug use _____
□ Nicotine use _____
□ Hearing impaired
□ Visually impaired
□ Burning upon urination
□ Bladder infection
□ Diabetes
□ Fibromyalgia
□ Post/Polio Syndrome
□ Cancer _____
□ Infectious disease
_____
□ Other congenital or Acquired disability
□ Other: _____

Please indicate area of concern:



Please list any surgeries, accidents, or injuries, with the date of occurrence:

Please list any medications:

Please list any supplements, herbal and/or homeopathic remedies:

Please list any additional therapist you have or are currently receiving (i.e. massage therapy, physiotherapy, chiropractic, naturopathy, homeopathy, acupuncture/acupressure, psychotherapy, etc.):

How do you feel about your general health? _____

How do you feel today? _____

Please explain the reason for your visit today: _____
_____

Are you in pain now? ___Y ___N Where is your pain? _____

Rate the severity of your pain/discomfort (1 = low ... 10 = high) 1 2 3 4 5 6 7 8 9 10

How would you describe your pain? _____

What (if anything) relieves the pain/discomfort? _____

What activities/actions aggravate the pain? _____

Is pain/discomfort affecting your regular daily activities? _____

HANDS ON HEALTH
MASSAGE THERAPY CENTRE

Consent to Treatment

Dear client,

Depending on my assessment, I may be treating you while you are on your stomach, back and/or side. I will work on several musculoskeletal structures of which I will describe before each and every treatment.

A sheet will cover you at all times, except for the area that I will be working on. I may use pillows under your abdomen and/or legs in order to make you more comfortable and support your lower back.

With treatment, your symptoms may decrease and you may observe an increased range of motion. To compliment Swedish massage, I may use stretches or hydrotherapy. In addition, I may refer you for another kind of therapy, depending on what I find.

A risk of treatment is that some techniques may be deep or uncomfortable. I will, however, adjust my pressure to your comfort level and check in with you during the treatment. It is possible you may feel a side effect such as achiness tomorrow, however if you follow the self-care suggestions I will give you after the treatments, this is less likely. It is also possible that without treatment, your condition may get worse, get better, or stay the same.

You may stop or modify your treatments at any time.

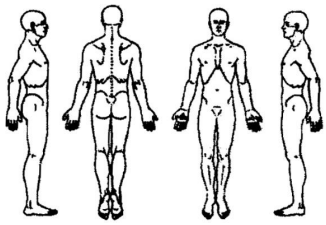
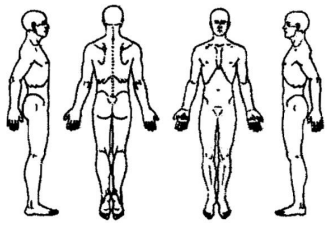
If an appointment is missed/cancelled without 24 hours notice, you will be billed for the time booked. I have allocated this time slot for you and your health and without proper notice it is difficult to schedule another client who may need the treatment time. Thank you for your consideration.

Do you consent to treatment? Yes No

Signature: _____ Date: _____

Client: _____ Client: _____

Date of treatment: _____ Date of treatment: _____

Response to last treatment:	Response to last treatment:
Client/treatment goals:	Client/treatment goals:
LORD FICARAH:	LORD FICARAH:
	
Treatment performed: VIC: □ Yes □ No	Treatment performed: VIC: □ Yes □ No
Re-assessment:	Re-assessment:
Ongoing tx plan:	Ongoing tx plan:
Home care:	Home care:

RMT: _____ Fees:____ RMT:_____ Fees:____

Duration:_____ Tx #:____ Duration:_____ Tx #:____