DOUGLASDALE
FAMILY CHIROPRACTIC

Massage Therapy Form

Today's Date: _____

AHC#: _____

Name: _____

Address: _____ Postal Code: _____

Phone (Home): _____ (Cell): _____

Date of Birth: _____ Occupation: _____

Email: _____

Allergies: _____

Current Medications including over the counter and supplements: _____

_____

Family Doctor: _____ Phone: _____

Emergency Contact: _____ Phone: _____

How did you hear about us?: _____

Have you received a professional Massage Treatment before?: **Yes** **No**

Put the appropriate **Letter** beside the symptom you may now or previously had: **P - for Past** **R - for Reoccurring** **C - for Current**

Musculoskeletal
Bone or Joint Disease ____
Tendonitis _____
Bursitis _____
Broken/fractured bones ____
Osteoarthritis ____
Rheumatoid arthritis ____
Neck/ whiplash/shoulder/arm injury ____
Back/hip/leg injury ____
Osteoporosis ____
Jaw/TMJ or ear pain ____
Headaches or migraine/ head injuries ____
Spasms/Cramps ____

Respiratory
Chronic cough ____
Chest pain ____
Asthma/Allergies____
Difficulty breathing ____

Other
Cancer/Tumors ___
Fibromyalgia ____
Epilepsy ____
Nervous disorders ____
Crohn's disease ____
Pelvic inflammatory disease ____
Diabetes ____

Skin
Dryness ____
Bruise easily ____
Allergies ____
Rashes ____
Athletes foot ____
Warts ____
Psoriasis ____
Eczema ____

Circulatory
Heart Condition ____
Varicose Veins ____
Lymphedema ____
High/low blood pressure ____
Fainting or dizziness ____
Phlebitis ____

Mental Health Condition ____
Poor nutrition ____
Drug Consumption ____
Nicotine _____
Caffeine ____
Alcohol Consumption ____

Digestive
Constipation ____
Diarrhea ____
Gas/Bloating ____
Diverticulitis ____
I.B.S. ____

Nervous System
Numbness/Tingling ____
Fatigue ____
Chronic pain ____
Herpes/ Shingles ____
Sleep Disorder ____

Genito-Urinary
Pregnant ____ if current # of weeks ____
PMS ___
Menopause ____
kidney disease ____
Frequent/painful urination ____
Prostate trouble _____

Family Health History (relationship)
Migraines _____
Arthritis _____
Heart Disease _____
Strokes _____
Diabetes _____
Cancer _____

Do you have any difficulty lying on your back, front or side? (circle all that applies) Explain: _____

_____

Do you perform repetitive movements in work, sports, hobby?: (circle all that applies) Explain: _____

_____

Do you experience stress in your work, family or others aspects of your life?: (circle all that applies)
Explain: _____

Did the current injury result from a motor vehicle accident or workplace injury?: **Y** **N**

Explain _____

Are you currently under medical supervision?: **Y** **N** Explain: _____

Do you see a chiropractor/ physiotherapist?: **Y** **N**

Have you had surgery in the past? **Y** **N** If yes, when and for what?: _____

_____

Have you taken any pain killers in the last 24 hours?: **Y** **N** Type: _____

Reason/goals for this treatment: _____

Are you in Pain?: **Y** **N** When did it begin?:_____ Location of pain:_____

Do you have allergies to oils, lotions or ointments?: (circle all that applies) Explain: _____

Are you wearing: Contact Lenses**:** **Y** **N** Hearing Aids**:** **Y** **N** Dentures: **Y** **N**

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 their professional membership. 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 ailments 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 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 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 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 confirm my 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 draping will be used during the session, and only the area being worked on will be uncovered. At any time I may withdraw my consent and treatment will be stopped.

Clients under the age of 18 years must be accompanied by a parent/guardian during the entire session unless waived by the parent/guardian.

We require 24-Hour Notice for cancellation appointments with our Massage Therapists.

If less than 24-Hours Notice is given, we reserve the right to charge the following:

1st time: 50% cost of visit

2nd time: 100% cost of visit

For no-show appointments, you will be charged 100% cost of visit.

Patient Name _____ Signature of Patient/Guardian _____

As parent/guardian, I agree not to be present during session (Initial) _____

Do you consent to cupping therapy (fire or glass) with Zorka Maric, RMT? **Yes** **No**

Witness _____ Date Signed _____