WATERDOWN MASSAGE & wellness clinic

Client Info/Health History and Consent to Treatment

All information will be kept in strict confidence.

_____ Please print full name clearly

_____/_____/ 2020

_____ Street address

_____ City Province Postal Code

_____-_____-_____

_____-_____-_____

_____@_____ Do you consent to email or text appointment reminders?

Date of Birth _____/_____/_____ **Occupation** _____ **EMAIL**_____ **TEXT**_____
MM/DD/YY YES/NO YES/NO

Did a health practitioner refer you for massage therapy? Name: _____

If NO, please tell us how you heard about Waterdown Massage & Wellness Clinic? _____

Check all treatments that you are currently receiving or have received within the past year:

□ massage therapy □ osteopathy □ chiropractic □ physiotherapy □ other ? _____

_____
Family physicians name and address

What is the reason you are seeking massage therapy? (location of tissue or joint discomfort) _____

List past injuries, accidents, and surgeries:

_____ date _____ _____ date _____

_____ date _____ _____ date _____

List all medications you are currently taking and the conditions they are treating:

medication _____ condition _____

medication _____ condition _____

ALERGIES? Yes! □ No □ If **yes**, please specify _____

Do you have any surgical implants (pins, plates, artificial joints)? □ Yes □ No If yes, specify _____

Are you currently pregnant? □ Yes □ No If yes, what trimester are you in? _____ What is your due date? _____

Do you have any of the following medical conditions?

ARTHRITIC CONDITIONS
□ osteoarthritis
□ rheumatoid arthritis
Is there a family history?
□ yes □ no

INFECTIOUS CONDITIONS
□ skin conditions
□ tuberculosis
□ hepatitis
□ HIV
□ herpes
□ other

RESPIRATORY CONDITIONS
□ chronic cough
□ shortness of breath
□ asthma
□ emphysema
□ bronchitis
□ other

NERVOUS SYSTEM CONDITIONS
□ epilepsy
□ paralysis or loss of sensation
□ multiple sclerosis
□ other

CIRCULATORY CONDITIONS
□ heart attack
□ stroke
□ pacemaker or other device
□ high blood pressure
□ low blood pressure
□ chronic congestive heart failure
□ atherosclerosis (hardening of arteries)
□ phlebitis (swollen vein)
□ severe varicose veins
□ Raynaud's disease
□ other_____

OTHER CONDITIONS
□ diabetes
□ kidney disease
□ cancer
□ anemia
□ hemophilia
□ digestive conditions
□ gynaecological conditions
□ fibromyalgia
□ osteoporosis
□ prolonged constipation
□ migraines
□ vision problems
□ hearing problems
□ mental illness
□ eczema
□ concussion
□ whiplash

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It is important that you understand and consent to the services we hope to provide to you, the cost involved, and what we do with personal information we obtain about you.

CONSENT FOR COLLECTION OF PERSONAL INFORMATION
I understand that to provide me with massage therapy treatment, Waterdown Massage & Wellness Clinic will collect some personal information about me. *All client information, written and verbal, is confidential and will remain so unless your written authorization is obtained or disclosure is required by law.*

CONSENT TO TREATMENT
We require your informed consent. As part of our profession's on-going commitment to provide quality care, it is important that you understand your rights as a client, thereby allowing you to make informed choices regarding your massage therapy treatment. You have the right to refuse, modify, or terminate the treatment or any aspect of it at any time.

- I understand that my consent is voluntary and that I may withdraw at any time.
- I am aware that massage therapy is not a substitute for a medical examination provided by a medical doctor.
- I have indicated all medical conditions that I am aware of and will inform the massage therapist of any changes in my health status.

CONSENT REGARDING THE COST OF OUR SERVICES
I agree to make payment in full at the conclusion of my treatment except where direct billing to a third party has been arranged in advance and **I accept that the full fee is charged for missed appointments unless 24 hours notice is given.**

I have reviewed Waterdown Massage Therapy's Privacy Policy about the collection, use and disclosure of personal information, steps taken to protect the information and my right to review my personal information. I understand how the Privacy Policy applies to me. I have been given a chance to ask any questions I have about the Privacy Policy and they have been answered to my satisfaction. I agree to Waterdown Massage & Wellness Clinic collecting, using, and disclosing personal information about me as set out above and in Waterdown Massage Therapy's Privacy Policy.

SIGNATURE: _____ DATE: _____

PRINTED NAME: _____

Do you consent to email communications such as appointment reminders, invoice statements &/or news letters? YES, I do ☐ please initial

Update 1 Client Signature _____ Date _____
Update 2 Client Signature _____ Date _____
Update 3 Client Signature _____ Date _____