

Leduc Wellness Centre Massage

CONFIDENTIAL HEALTH RECORD

Today's Date: _____

Name: _____ Home Phone: _____

Date of Birth: ____/____/____ Cell Phone: _____
mm dd yr

Email (appointment reminders and/or receipts): _____

Mailing address: _____

City, Province, Postal Code: _____

Occupation: _____ Business phone: _____

How did you hear about Leduc Wellness Centre? _____

Reason for initial visit: _____

Serious illnesses, injuries, or surgeries: _____

Medications: _____

Family physician: _____ Phone: _____

Emergency Contact: _____ Phone: _____

Do you wear contact lenses? Yes No

Please check spaces below for any conditions that you are experiencing or have experienced and inform the Massage Therapist about any changes in your condition immediately (before, during and after treatment).

Soft tissue/joints

- tendonitis/bursitis
- weakness: _____
- sprains/strains
- arthritis OA/RA/other
- herniated disc

Headaches

- migraines
 - tooth/jaw/ear pain
 - tension
 - head trauma
- date: _____

Accident/Injury

- car accident
 - whiplash
- symptoms: _____
- physical limitations: _____

Skin

- bruise easy
- herpes
- varicose veins
- athletes foot
- warts/ plantar warts
- loss of sensation

Women

- pregnant/ due date: _____
- gynecological conditions

Respiratory

- pneumonia
- shortness of breath
- bronchitis
- sinus problems
- chronic cough
- asthma

Cardiovascular

- pacemaker
- heart attack
- phlebitis
- stroke / CVA
- angina
- heart disease
- chronic congestive heart failure
- high blood pressure
- low blood pressure

Infectious Disease

- hepatitis A / B / C
- tuberculosis
- HIV / AIDS

Other Conditions

- hemophilia
 - emphysema
 - neurological conditions
 - epilepsy
 - insomnia/poor sleeping
 - kidney / bladder problems
 - diabetes
 - allergies
- specify: _____
- anaphylaxis Y / N
 - cancer: _____
 - vision problems
 - fibromyalgia
 - hearing loss or tinnitus
 - constipation
 - other digestive condition
- date: _____
- _____
- _____
- osteoporosis
 - surgical implants: _____
- _____
- other: _____
- _____

INFORMED CONSENT

PLEASE TAKE A MOMENT TO CAREFULLY READ THE FOLLOWING AND SIGN WHERE INDICATED

The above information is accurate to the best of my knowledge and I freely give my permission to be massaged. Since massage is contraindicated for some serious medical conditions, it may be necessary to obtain a doctor's release or prescription before beginning massage. I understand that massage therapy should not be construed as a substitute for medical examination, diagnosis, or treatments and that I should see a medical or chiropractic doctor or other healthcare specialist. I agree to update the massage therapist in regard to changes in my health and understand that there shall be no liability on the therapist's part should I forget to do so.

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 are risks involved with massage therapy, including but not limited to: muscle tenderness, stiffness, and sometimes slight bruising which has been explained to me and I assume those risks. I do not expect the therapist to be able to anticipate and explain all of the risks and complications associated with massage. I wish to rely on the practitioner to exercise judgement during the course of my treatment(s) based on the facts known.

I understand that:

- The relationship between the client and massage therapist is a confidential one and that all information provided to the therapist is to be kept confidential. However 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 billing companies.
- My body will be properly draped at all times for comfort, security and warmth.
- The massage is solely for the purpose of therapeutic massage and that the massage therapist also has the right to be free from any unwanted, harmful, offensive, and /or physical contact or behaviour. This will result in a termination of the session and I will be responsible to pay for the entire session.
- I will inform the therapist of any discomfort, so that the application of pressure or stroke may be adjusted to my level of comfort.
- **Should I have to cancel the appointment for any reason, I agree to give the therapist 24 hours' notice or I will be billed 50% of the cost of the appointment missed.**
- By signing this form, I give consent for future sessions. I have read this form and hereby freely give my permission to be massaged.
- I understand that at any time I may withdraw my consent and treatment will be stopped.
- Fees are due at time of service.

Client Signature: _____ Date: _____

Consent to treatment of minor - by my signature, I hereby authorize my child or dependant to have massage treatments administered.

Signature of parent/guardian: _____ Date: _____