



Massage Therapy Informed Consent

PLEASE NOTE THAT THIS FORM MUST BE SIGNED PRIOR TO YOUR 1ST APPOINTMENT

We would like to take this opportunity to welcome you to Lakeside Natural Health Centre. This clinic utilizes the principles and practices of Massage Therapy. Massage Therapists assess and treat physical dysfunction and pain of the soft tissue and joints of the body, mostly by hands-on manipulation. Assessment and treatment can include orthopaedic and neurological testing, soft tissue manipulation (Swedish massage is the most commonly used technique), hydrotherapy, remedial exercise programmes and client education programmes.

The treatment and advice provided to you by the Registered Massage Therapist is not being provided in place of, or to the exclusion of, any other treatment or advice that you may now be receiving, or may in the future receive, from a physician, surgeon, or any other licensed health practitioner. It is your responsibility to inform your therapist of any pre-existing medical conditions, injuries or disease of which you are currently aware of. It is your right and responsibility to inform the therapist of your condition during the course of your treatment. The Registered Massage Therapist reserves the right to discontinue services where it is apparent that your expectations and the type of services provided are not compatible.

Privacy of your personal information is an important part of providing you with quality Massage Therapy. We understand the importance of protecting your personal information and are committed to collecting, using and disclosing your personal information responsibly. Our privacy protocol complies with privacy legislation and standards set out by the Registered Massage Therapists' Association of Ontario.

I understand that a confidential record will be kept of the health services provided to me. This record will be kept confidential but if required, I understand that my Massage Therapist may discuss my case with other healthcare providers. I understand that I may look at my medical records at any time and can request a copy of my file with a fee of \$0.10 per page. I understand that information from my medical records may be analyzed for research purposes and that my identity will be protected and kept confidential.

I understand that the results are not guaranteed. I do not expect Registered Massage Therapists to be able to anticipate and explain all risks and complications. With this knowledge, I voluntarily consent to massage therapy. I intend this consent form to cover the entire course of treatment. I understand that I am free to withdraw my consent at any time.

Patient Name (Please print name): _____
 Signature of Patient or Guardian: _____ Date: _____
 Massage Therapist Name: _____ Massage Therapist Signature: _____

The vision of Lakeside Natural Health Centre is to provide true integrative health care. Given our commitment to this best-patient practice, we will communicate with your other practitioners at our clinic to ensure that you are receiving true complementary care. This will be done with respect for all privacy laws and any restrictive stipulation you may have placed on this communication. Please speak to your practitioner if you would like more clarification on this process.

I welcome professional dialogue regarding my case between members of my health care team at Lakeside Natural Health Centre (please circle): Yes / No

Signature: _____



Massage Therapy Intake Form

Please complete both sides of the following form to provide us with the background information we require to ensure you receive comprehensive care.

Contact Information:

Name _____
 Date of Birth M _____ D _____ Y _____
 Gender (circle) Male / Female Age _____
 Home # _____
 Address _____

 Email _____

Occupation _____
 Work # _____
 Cell # _____
 Emergency Contact _____
 Emergency Contact # _____
 Parent or Guardian Name
 (If under 16 years) _____

YES / NO Can we send you our monthly newsletter and new event listings via email? Your email address will not be shared.

How did you hear about Lakeside Natural Health Centre? _____

Health Care Providers:

Medical Doctor _____ Specialist _____
 Phone # _____ Fax # _____ Phone # _____ Fax # _____

General Information (please circle):

Have you received massage therapy before? YES / NO Medications and conditions they treat: _____
 Did a health care practitioner refer you? YES / NO If yes please provide name and number: _____
 General state of health: excellent good fair poor Please list any other medical conditions: _____
 Please list any other treatment you are receiving that may impact your treatment: _____
 Please indicate if you have any internal pins, wires, artificial joints or special equipment and where: _____
 Reason for seeking massage therapy (Please include location of any tissue or joint discomfort: _____
 Please list any surgery or injuries including dates: _____
 Do you have group benefit coverage? YES / NO

Check off any of the following if they are a CURRENT or RECURRING symptom:

<u>Cardiovascular:</u>	<u>Respiratory:</u>	<u>Infections:</u>	<u>Head / Neck:</u>	<u>Other Conditions:</u>	<u>Woman:</u>
<input type="checkbox"/> High blood pressure	<input type="checkbox"/> Chronic cough	<input type="checkbox"/> Hepatitis	<input type="checkbox"/> History of headaches	<input type="checkbox"/> Loss of sensation	<input type="checkbox"/> Pregnant
<input type="checkbox"/> Low blood pressure	<input type="checkbox"/> Shortness of breath	<input type="checkbox"/> Skin conditions	<input type="checkbox"/> History of migraines	<input type="checkbox"/> Diabetes	Due date _____
<input type="checkbox"/> Heart attack	<input type="checkbox"/> Bronchitis	<input type="checkbox"/> TB	<input type="checkbox"/> Vision problems	<input type="checkbox"/> Allergies	<input type="checkbox"/> Gynaecological conditions
<input type="checkbox"/> Stroke /CVA	<input type="checkbox"/> Asthma	<input type="checkbox"/> HIV	<input type="checkbox"/> Vision loss	<input type="checkbox"/> Hypersensitivity	
<input type="checkbox"/> Phlebitis / varicose veins	<input type="checkbox"/> Emphysema	<input type="checkbox"/> Herpes	<input type="checkbox"/> Ear problems	<input type="checkbox"/> Epilepsy	
<input type="checkbox"/> Heart disease			<input type="checkbox"/> Hearing loss	<input type="checkbox"/> Cancer	
<input type="checkbox"/> Chronic congestive heart failure				<input type="checkbox"/> Skin conditions	
<input type="checkbox"/> Pacemaker or similar device				<input type="checkbox"/> Arthritis	
<input type="checkbox"/> Circulatory problems				<input type="checkbox"/> Sensitivity to scents	

Billing Authorization:

Credit Card on File:

Client's Name: _____ Name as it appears on the credit card: _____
 Type of credit card (please circle): MasterCard / Visa Card #: _____
 Expiration Date (month/year): _____

Cancellation Policy:

Your appointment has been reserved especially for you therefore we ask that you provide the clinic with at least 48 hours advance notice if you need to cancel your appointment. Cancellations with less than 48 hours' notice are subjected to a charge of 100% of the fee for the service scheduled. We appreciate your cooperation with our clinic policy.

I, _____, authorize Lakeside Natural Health Centre to process the above credit card as "Signature on File" for any balance due on my account past 30 days and for any appointments not cancelled in accordance with Lakeside Natural Health Centre's cancellation policy. I understand that a receipt will be promptly sent to me upon any charges.

Patient / Cardholder's Signature: _____ Date: _____