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: ________________________

Lakeside Natural Health
CENTRE
HEAL · GROW · THRIVE

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 ______________________________________
Address: ____
Phone # __________________ Fax # __________________

Specialist ____
Phone # __________________ Fax # __________________

General Information (please circle):

Have you received massage therapy before? YES / NO
Did a health care practitioner refer you? YES / NO
General state of health: excellent good fair poor

Medications and conditions they treat: ______________________________________
If yes please provide name and number: ______________________________________
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:

Cardiovascular:
- ☐ High blood pressure
- ☐ Low blood pressure
- ☐ Heart attack
- ☐ Stroke /CVA
- ☐ Phlebitis / varicose veins
- ☐ Heart disease
- ☐ Chronic congestive heart failure
- ☐ Pacemaker or similar device
- ☐ Circulatory problems
- ☐ History of myocardial infarction
- ☐ History of cerebrovascular accident

Respiratory:
- ☐ Chronic cough
- ☐ Shortness of breath
- ☐ Bronchitis
- ☐ Asthma
- ☐ Emphysema
- ☐ Family history of cardiovascular difficulty

Infections:
- ☐ Hepatitis
- ☐ Infectious Skin conditions
- ☐ TB/Infectious respiratory conditions
- ☐ HIV
- ☐ Herpes

Head / Neck:
- ☐ History of headaches
- ☐ History of migraines
- ☐ Vision problems
- ☐ Vision loss
- ☐ Ear problems
- ☐ Hearing loss

Other Conditions:
- ☐ Loss of sensation
- ☐ Diabetes
- ☐ Allergies
- ☐ Hypersensitivity
- ☐ Epilepsy
- ☐ Cancer
- ☐ Skin conditions
- ☐ Arthritis
- ☐ Family history of arthritis
- ☐ Sensitivity to scents

Woman:
- ☐ Pregnant
  Due date ___________
- ☐ Gynaecological conditions

Other Conditions:
- ☐ Diagnosis of Medical Condition

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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: _________________________