

MASSAGE on 194th
228 – 803 Chaparral Drive SE,
Calgary, AB T2X 0E5
(403) 873-9555

Client Health Intake and Consent Form

Name: _____ Birthdate: _____
(mm/dd/yyyy)

Address: _____
(City) (Province) (Postal Code)

Best Contact Number(s): _____

E-mail: _____

Emergency Contact: _____
(Name) (Relationship) (Telephone)

HOW DID YOU FIND US? _____

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Have you had Massage before? YES NO

Primary reasons for seeking treatment:

____ relaxation/stress reduction ____ headaches/migraines
____ muscle soreness/stiffness ____ motor vehicle accident
____ prenatal/postnatal treatment
____ treatment of injury/condition (please specify) _____
____ other (please specify) _____

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Have you had any injuries, sprains, fractures, or surgeries within the past 72 hours? YES NO

Explain _____

Indicate any past serious illnesses, accidents, injuries or surgeries? (Nature, date, and remaining aftereffects)

What medications are you currently taking? (Prescription and over the counter)

(Please turn over to fill out reverse side)

Please CHECK MARK all that apply to you and if check marked, please explain as clearly as possible:

(FEMALES) pregnant (How many weeks?) _____

(FEMALES) PMS or menopausal symptoms _____

Allergies (please specify) _____

High blood pressure (Is it controlled by medication?) _____

Heart problems including cardiac pacemaker _____

Blood clotting disorders _____

Blood thinning medications _____

Bruise easily _____

Varicose veins/phlebitis _____

Open wounds _____

Skin rashes/acne _____

Sexually transmitted diseases (STIs)/HIV/AIDS _____

Other contagious disease (please specify) _____

Asthma _____

Cancer _____

Arthritis _____

Epilepsy/seizures _____

Diabetes _____

Fibromyalgia _____

Multiple sclerosis _____

Bowel diseases (irritable bowel, colitis, Crohn's) _____

Headaches/migraines _____

Temporomandibular joint (TMJ) disorder _____

Whiplash _____

Carpal tunnel syndrome _____

Rotator cuff injury/surgery _____

Thoracic outlet syndrome _____

Scoliosis _____

Sciatica _____

Vertebral disc problems _____

Foot problems (bunions, corns, warts, calluses, fungus) _____

Contact lenses/dentures/hearing aids _____

Transdermal patch medication _____

Pins, plates, or screws, joint replacements _____

Depression _____

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 treated.

By signing this form, I hereby consent for assessment and treatment by a licensed Massage Therapist. There can be possible discomfort and risks during assessment / treatment which include, but not limited to pain, muscle strain, and burn. There is no guarantee that the proposed course of treatment will improve my condition. I give consent to share/disclose my health information related to my condition for the purpose of carrying out treatment, communicating with the referring physician or for obtaining payment. I understand that the sole purpose of some treatments is for relaxation and body balance. This treatment* is not a substitute for medical examinations and/or diagnosis and it is recommended that I see a physician for any physical ailment that I might have. My body will be properly covered/draped at all times for comfort, security and warmth according to the type of treatment I am having. **I will inform the practitioner of any discomfort, so that the application of the treatment may be adjusted to my level of comfort.** I have the right to request and require that any procedure or technique be modified, changed, stopped, or simply not performed. The practitioner also has the right to be free from any unwanted, harmful, or offensive physical contact or behaviour. I agree to update the practitioner regarding changes in my health and understand that there shall be no liability on the practitioner's part should I forget to do so. By signing this form, I also give consent for future sessions. **Unless there is an emergency, we reserve the right to charge \$40.00 for any changed, missed or cancelled appointments without you giving 24 hours' notice. We regret that we cannot give you additional time if you arrive late for your appointment and you will be charged for the full appointment time.** Client Initials _____

(CLIENT - PRINT NAME)

(DATE)

(CLIENT SIGNATURE)

(PRACTITIONER SIGNATURE)