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?____
(If a person, please give name.)

Have you had Massage before? YES NO

Primary reasons for seeking treatment:

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

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 herby 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)	(PRACTITONER SIGNATURE)