Massage Therapy Consent and Disclaimer Form

Date: ____________________________

Therapist: ____

I understand that the above massage therapist does not diagnose illness, disease or any other physical or mental disorder and does not prescribe pharmaceuticals or medical treatment. It has been made clear to me that this massage therapy session is not a substitute for any medical examinations and/or diagnosis and that it is recommended that I see a physician for any physical ailment I may have.

Due to the fact that the massage therapist must be aware of any existing physical conditions of clients treated, I have stated any/all of my known medical conditions and if necessary give permission to the therapist to consult with my physician.

I assume all risks and perils to my person physically, physiologically or psychologically which may ensue during this or subsequent treatments. As well as any effects deemed detrimental which may ensue afterwards as a result of this or subsequent treatments.

I have read all of the above information and fully understand what has been stated and expected from me.

CLIENT'S NAME: ____

CLIENT'S SIGNATURE: ____

FIRST NAME:__________________________ **LAST NAME:** ______________________________

ADDRESS: ____ **POSTAL CODE:** ______________

PHONE (home): __________________________ **(work/cell):** ____________________________

AGE: ______________ **BIRTHDATE:** ____

EMAIL ADDRESS: ____

MANITOBA BLUE CROSS POLICY#: ________________________ **ID#:**______________________

HOW DID YOU HEAR ABOUT US?:____

PHYSICIAN: ____

CHIROPRACTOR or PHYSIOTHERAPIST:____

PRIMARY REASON FOR APPOINTMENT:____

HAVE YOU EVER HAD A THERAPUTIC MASSAGE BEFORE?: _______________________________

<u>CLIENT HISTORY</u>

Do you have a current health status or a history of any of the following? If **YES** please indicate.

Heart Problems, Chest discomfort/pressure pain, Heart disease? .... YES NO

Sudden tingling, Numbness in arms, hands, chest, face, feet or legs? .... YES NO

Told that you have high or abnormal blood pressure? .... YES NO

Respiratory or breathing problems (asthma, allergies, bronchitis)? .... YES NO

Diabetes? If so how is it controlled? .... YES NO

___Diet ___Oral medication ___Insulin injections ___uncontrolled

Faintness, Dizziness, Lightheadedness or Blackouts? .... YES NO

Have frequent headaches? .... YES NO

Wear contact lenses? .... YES NO

Have varicose veins? .... YES NO

Have arthritis or osteoporosis? .... YES NO

Joints affected: ____

Ever had cancer? .... YES NO

Type?: ____

Chronic diarrhea or constipation? .... YES NO

Currently taking **any** medications? .... YES NO

____

Suffered from a severe injury or have been hospitalized .... YES NO

____

Received Cortisone injections? If so when and where? .... YES NO

____

Any skin conditions or reactions to lotions or creams?...................................... YES NO

____

Have concerns about your sleep pattern, appetite or current level of stress?
Please describe briefly.

____

____

CURRENT HISTORY

Dominant Side

R________ **L**________

Please use the body picture to indicate the area(s) which is currently problematic for you.

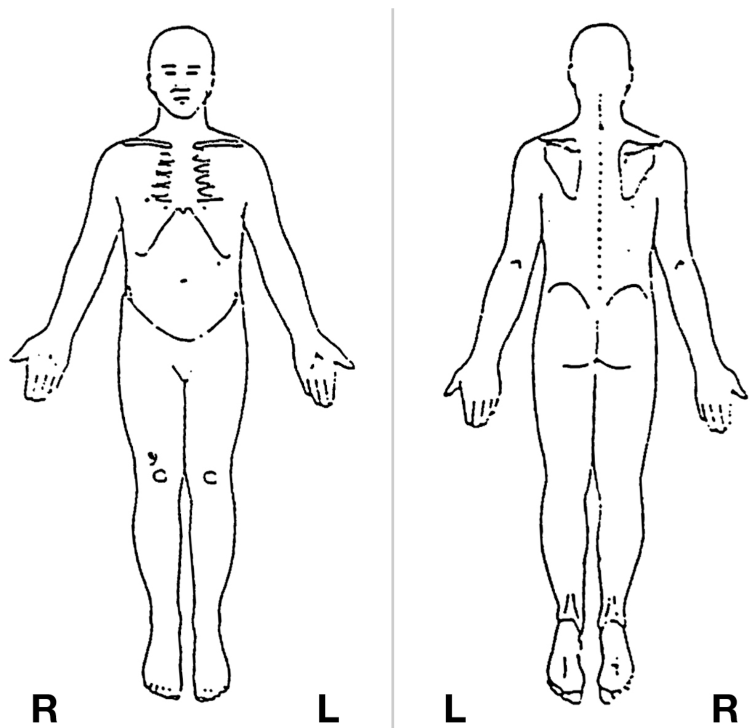
******* To indicate tingling or numbness

- - - To indicate heat or burning

/ / / To indicate pain

o o o To indicate swelling or loss of mobility

x x x To indicate other



LIFESTYLE

Occupation: ____

Types of physical activities involved:

____

Recreational activities and interests:

____

EXPECTATIONS

Client expectation/goals of treatment:

____

Therapist expectation/goals of treatment:

____

The client and therapist have understood and agreed upon realistic expectations and goals of treatment. These outcomes will be reviewed and updated at the beginning of each session.