

Name: \_\_\_\_\_ Date: \_\_\_\_\_

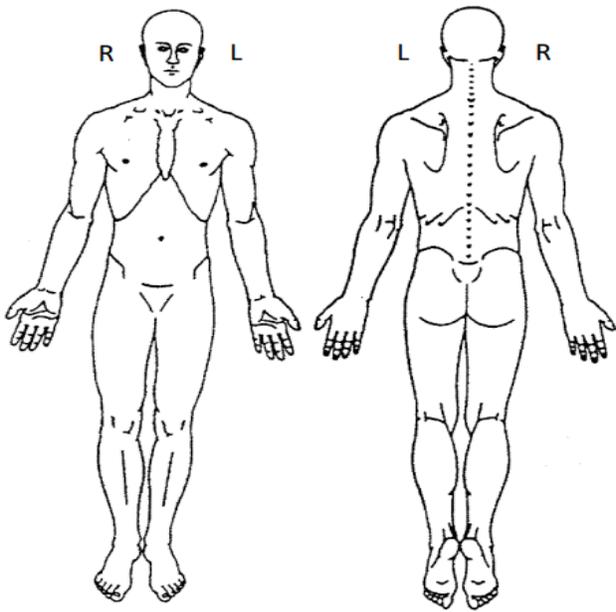
**Contact Info:**

Home Phone. \_\_\_\_\_ Address \_\_\_\_\_

Work / Cell Phone. \_\_\_\_\_ City \_\_\_\_\_

Email \_\_\_\_\_ Birth Date \_\_\_\_\_

**1) On the diagram below, please circle areas that give you irritation or pain:**



**2) Please describe your primary complaint(s) circled on the diagram above:**

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**3) What is your current occupation?**

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4) Have you had a massage before?

Yes

No

5) Do you Exercise?

Yes

If yes, what type of physical activities?

No

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6) Please list all current medical conditions: \_\_\_\_\_

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7) Please list all Major Surgeries or Injuries: \_\_\_\_\_

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8) Please list all current medications: \_\_\_\_\_

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9) Please list all current allergies: \_\_\_\_\_

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10) Are you presently in treatment with other Health Care Practitioners (DR, PT, etc.)?

If yes, specify: \_\_\_\_\_

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Emergency Contact Person: \_\_\_\_\_

Phone Number: \_\_\_\_\_ Relationship: \_\_\_\_\_

## **Informed Consent to Remedial Massage Therapy Care**

I hereby request and consent to the performance of Remedial Massage Therapy and other massage procedures, including various forms of physical therapy. I understand that Massage Therapy is not a replacement for Medical Care and no diagnosis will be made. I understand that the Massage Therapist must be aware of any existing physical conditions and have stated all my known medical conditions. Also, I will keep the Massage Therapist updated on my physical health.

I understand and am informed that, as in all health care, in the practice of Remedial Massage, there are some very slight risks to treatment, including, but not limited to, bruising, muscle soreness, muscle strains and sprains, disc injuries and strokes. I do not expect the Massage Therapist to be able to anticipate and explain all risks and complications, and I wish to rely on the Massage Therapists to exercise judgement during the course of the procedure, which the Massage Therapist feels at the time, based upon the facts then known, is in my best interests.

I have read the above consent. I have also had the opportunity to ask questions about its content, and by signing below I agree to the above-named procedures. I intend this consent form to cover the entire course of treatment for my present condition and for any future condition(s) for which I seek treatment.

Signed: \_\_\_\_\_ Date: \_\_\_\_\_

I certify that I am aware of PIPEDA and have read the authorization and consent above. GDM Massage Therapy respects personal confidentiality and will not share personal health information with any third party without your written consent. I understand that the charges listed for Massage Therapy treatments may not be covered by or may exceed my policy benefits. I understand that I am financially responsible to the Massage Therapy provider, GDM Massage Therapy, for the cost of treatment. I understand that if I choose to suspend Massage Therapy care, any fees for Massage Therapy services rendered to me will be due and payable immediately. I understand that a minimum of 24 hours notice is required to cancel a Massage Therapy appointment. Failure to do so, or failure to show will result in a billing of 100% of treatment fees.

Signed: \_\_\_\_\_ Date: \_\_\_\_\_