essential massage therapy

Suite 103 - 4180 Lougheed Hwy. Burnaby, BC Canada V5C 6A7 Phone: **604.293.2273** Fax: **604.473.9070**

Dear patient/client:

Please complete this questionnaire. Your answers will help us determine what the cause of your problem may be. As well, they will indicate which massage therapy modality can best serve you. Thank you.

Name _____

Address _____ City, Province _____

Postal code _____ Phone (Home) _____ (Work) _____

Age _____ Date of birth (month/day/year) _____

email _____

Personal Healthcare Number _____

Marital status: S ____ M ____ W ____ D ____

Occupation _____

Hobbies and interests _____

Medical Doctor _____ Phone _____

Address _____

How did you hear about our office?

Family ____ Friend ____ Doctor ____

Phone book ____ Sign ____ Other _____

MEDICAL HISTORY

Please check if you have had any of the following conditions. Please mark down with the initials P-past, C-current, F-family history.

Allergies	___	Epilepsy	___	Insomnia	___	Spinal injury	___
Arthritis	___	Fractures	___	Jaw pain	___	Sprain/strain	___
Cancer	___	Headaches	___	Joint pain	___	Stroke	___
Circulatory	___	Head injury	___	Kidney	___	STD's/VD	___
Diabetes	___	Heart condition	___	Nausea	___	Thyroid	___
Digestive	___	High/low BP	___	Pregnancy	___	Varicose veins	___
Dislocation	___	HIV	___	Respiratory	___	Other	_____

Do you wear/have: pins/plates ____ orthotics ____

Do you exercise regularly? If yes, what and how much?_____

Do you smoke? If yes, how much? _____

Do you drink? If yes, how much? _____

Have you ever had any major surgery or illness? If yes, please describe _____

_____

Are you presently taking any medications? If yes, what type and for what condition _____

_____

REASON FOR CONSULTING THIS OFFICE

Type of claim: WCB _____ ICBC _____ MSP _____ Other _____

Briefly describe your major complaint _____

_____

_____

How long have you had this problem? _____

Have you had this, or similar problem in the past? _____

Is this condition getting:

Worse _____ Unchanged _____ Better _____

Is this condition interfering with your:

Work _____ Sleep _____ Daily routine _____ Other _____

Have you had any other health care practitioner(s) treat this condition? _____

If so, who? _____

Any other complaints? _____

INFORMED CONSENT TO MASSAGE THERAPY

This clinic makes every effort to ensure that your treatment is safe and effective. In particular, you should note:

a) *Potentially painful treatments*. Although some treatments maybe painful, every effort is made to minimize the discomfort. Treatment can cease or be modified at anytime at the patients request.

b) *Removal of clothing*. Only in the areas to be treated, is the removal of certain clothing preferred for effective treatment. It is the right of the patient to decline the removal of certain or any clothing. If the patient wishes, they have the option of bringing and wearing shorts and sports bra (for women) during their treatment.

c) *Files*. This clinic will be keeping all recorded information as part of your patient file. It is under the personal agreement that any of the information given will be kept completely confidential. If your file is ever needed in a legal matter, your file will not be released without your prior consent.

d) *Cancellations, lateness, and "No Shows"*. Cancellations must be made 24 hr. prior to appointment time, otherwise a charge of **$20** will be assessed. **"No shows" will be assessed the full amount**. For the consideration of staff and other patients, please do not be late for your appointment. In the event that you are late, we may be unable to accommodate your treatment time.

I acknowledge I have discussed, or have had the opportunity to discuss, with my Registered Massage Therapist the nature and purpose of massage therapy.

I consent to the massage therapy treatment offered or recommended to me, by my Registered Massage Therapist. I intend this consent to apply to all my present and future massage therapy care.

Dated this _____ day of _____, 20_____.

Patient name:_____
(please print)

Witness name:_____
(please print)

Patient signature:_____

Witness signature:_____