CLIENT INFORMATION

Name: _____

Birthdate (D/M/Y): _____ Age: _____ Gender_____

Address _____
(Street)

_____
(City) (Postal Code)

Guelph Performance Therapy

Home Ph.#_____ Cell: _____ Email: _____

Occupation: _____ Sport: _____ Activity Level: low / med / high

Can your email address be used to contact you concerning your care? Y / N

Permitted Methods of Communication: Phone Text Email (please indicate preferred phone number)

How did you hear about us? ❑ Moves Member ❑ Website ❑ Social Media ❑ Field Therapist ❑Other: _____

Name of Medical Doctor: _____ Permission to Contact Y / N Initial: _____

Address of Medical Doctor: _____

Emergency Contact: _____ Relation: _____ Phone: _____

Are you currently being treated by another health care professional? Y / N _____

Have you received massage therapy or athletic therapy previously? Y / N _____

Is there any chance of pregnancy? Y / N Due Date: _____

MAIN HEALTH CONCERNS

My usual health is ❑ Excellent ❑ Good ❑ Fair ❑ Poor

PERSONAL HISTORY

Head / Neck
- □ Headaches (tension / Migraine)
- □ Vision / Hearing problems
- □ Ear / Jaw / Tooth Pain
- □ Head Trauma / Concussion
- □ Allergies
- □ Neck Pain / Stiffness / Injury

Skin
- □ Sensitive Skin
- □ Rashes / Eruptions
- □ Cold Sores / Herpes
- □ Contagious conditions
- □ Bruise Easily
- □ Loss of Sensation

Digestive
- □ Constipation / Diarrhea / Nausea
- □ Gas
- □ Liver / Gal Bladder
- □ Ulcer
- □ Alcohol Consumption (concerning)

Respiratory
- □ Chronic Cough
- □ Chronic Congestion
- □ Asthma / Bronchitis
- □ Emphysema
- □ Shortness of Breath
- □ Family History of the above

Cardiovascular
- □ High / Low Blood Pressure
- □ Poor Circulation / Sensation
- □ Congestive Heart Failure
- □ Varicose Veins / Phlebitis
- □ Dizziness
- □ Chest Pain / Angina / Pace Maker
- □ Heart Disease
- □ Heart Attack / Stroke
- □ Phlebitis / Varicose Veins
- □ Pacemaker or similar device
- □ Family History of the above

Other
- □ Cancer
- □ Epilepsy / Seizures
- □ Hepatitis
- □ HIV
- □ Hemophilia
- □ Lupus
- □ Diabetes
- □ Bone / Joint / Nerve
- □ Arthritis
- □ Family History of Arthritis
- □ Mental Illness
- □ Gynecological Conditions
- □ Pins / Plates / Implants etc.
- □ Other:
- □ _____
- □ _____
- □ _____

Notes:

Please list previous hospitalizations, car accidents, surgeries, major accidents etc. & the nature of your injuries:

_____

_____

Please list treatment that you have received for previous injuries:

_____

_____

Please list any imaging (CT Scan, MRI, X-ray) received:

_____

List any real or suspected allergies / sensitivities to drugs, food, alcohol, caffeine, chemicals, perfumes, smoke etc:

_____

List any medications or supplements you are currently taking, and what they are for:

_____

CURRENT COMPLAINTS (WHY ARE YOU SEEKING TREATMENT)

Main Concern: _____When did it start? _____

What aggravates your discomfort?:_____

What makes you feel better?:_____

Indicate the areas in which you are experiencing pain, and would like to be assessed and/or treated:

- □ Head
- □ Neck
- □ Jaw
- □ Shoulder
  - o Left
  - o Right
- □ Chest
- □ Upper back
- □ Lower back
- □ Gluteal region
- □ Pelvic Girdle
- □ Hip
  - o Left
  - o Right
- □ Knee
  - o Left
  - o Right
- □ Upper Leg
  - o Left
  - o Right
- □ Lower Leg
  - o Left
  - o Right
- □ Foot
  - o Left
  - o Right
- □ Arm / Elbow
  - o Left
  - o Right
- □ Hand
  - o Left
  - o Right
- □ Abdomen

I confirm that this health history is complete and correct. I acknowledge that if I do not disclose a condition or history of a condition to my Therapist then it might create an unsafe situation for me during my treatment. I understand that it is my responsibility to update my Therapist if any medical conditions change, or I develop new ones.

Printed Name _____ Signature _____ Date _____

If Under 18, Parent or guardian Signature: _____

CONSENT TO TREATMENT

I acknowledge that I am receiving **Massage Therapy** treatment from a Registered Massage Therapist (RMT), registered with the College of Massage Therapists of Ontario. I understand that the treatment provided is within the scope of practice, including but not limited to assessments, treatment, manual therapy, taping, modalities, stretching and remedial exercise.

I understand that my Massage Therapist does not diagnose injuries or illnesses. Massage Therapy is not a substitute for medical examination, and it is recommended that I see my medical doctor for all injuries and illnesses.

As a patient, I have the right to be informed about my health condition(s) and recommended treatments. I understand that it is my right to determine the course of my treatment and may modify or terminate treatment at any time. My therapist will discuss the potential benefits, risks and hazards involved. I recognize that even the gentlest therapies may potentially have risk of complications.

I understand that I have no been given any guarantees in my course of treatment and that results may vary.

I intend this as a form to cover my entire course of treatments including any future conditions for which I seek treatment.

I understand that I can alter or rescind my consent at any time during this or any treatment. **Initials:** _____

RELEASE OF PERSONAL INFORMATION

I hereby fully authorize the Massage Therapist to exchange medical and/or other information necessary with other medical professionals handling my case, third party payers & insurance companies. **Initials:** _____

CANCELLATION AND NO-SHOW POLICY

I understand that there is a 24-hour cancellation policy for all appointments. I understand that if I cancel or fail to show for any scheduled appointments I will be charged in full. **Initials:** _____

FEES AND PAYMENT

Massage Therapy fee schedule

Initial Treatment – 60 minutes - $90.00 (HST included)
Follow Up Treatment – 60 Minutes - $90.00 (HST included)
Follow Up Treatment – 45 Minutes - $75.00 (HST Included)
Follow Up Treatment – 30 Minutes - $60.00 (HST Included)

I understand that it is my responsibility to pay in full for all services rendered. I understand that regardless of third party claims and benefits, I am responsible for payment. I acknowledge that my massage therapist is not responsible for filing claims on my behalf. **Initials:** _____

I have read, understood and agree to all the above information

Name: _____ Signature: _____

Date: _____ Witness: _____

If Under 18, Parent or guardian Signature: _____