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INFORMED CONSENT TO MASSAGE THERAPY TREATMENT

I understand that the massage therapist is providing massage therapy services within their scope of practice as defined by The Physiotherapy Center Ltd.

I hereby consent for my therapist to treat me with massage therapy for the above noted purposes including such assessments, examinations and techniques, which may be recommended, by my therapist.

I acknowledge that the therapist is not a physician and does not diagnose illness or disease or any other physical or mental disorder. I clearly understand that massage therapy is not a substitute for a medical examination. It is recommended that I attend my personal physician for any ailments that I may be experiencing. I acknowledge that no assurance or guarantee has been provided to me as to the results of the treatment. I acknowledge that with any treatment there can be risks and those risks have been explained to me and I assume those risks.

I acknowledge and understand that the therapist must be fully aware of my existing medical conditions. I have completed my medical history form as provided by my therapist and disclosed to the therapist all of those medical conditions affecting me. It is my responsibility to keep the massage therapist updated on my medical history. The information I have provided is true and complete to the best of my knowledge.

I authorize my therapist to release or obtain information pertaining to my condition(s) and/or treatment to/from my other caregivers or third party payers.

I have read the above noted consent and I have had the opportunity to question the contents and my therapy. By signing this form, I confirm my consent to treatment and intend this consent to cover the treatment discussed with me and such additional treatment as proposed by my therapist from time to time, to deal with my physical condition and for which I have sought treatment. I understand that at any time I may withdraw my consent and treatment will be stopped.

Patient Name _____ Signature of Patient/Guardian _____

Witness _____ Date Signed _____

HEALTH HISTORY FORM – MINIMUM REQUIREMENTS

Name: _____ **Date of initial visit:** _____

Address: _____ **Phone number:** _____

Date of birth: _____ **Referred by:** _____

Physician name: _____ **Allergies:** _____

Sports & activities: _____

Current medications: _____

Are you under medical care for any of the following: (circle)

heart conditions	high/low blood pressure	fainting or dizziness
varicose veins	phlebitis/circulatory problems	headaches or migraine
neck injury	back injury	jaw or ear pain
osteoporosis	rheumatoid arthritis	osteoarthritis
cancer	kidney disease	skin conditions
diabetes	asthma/respiratory	fibromyalgia
Crohn's disease	pelvic inflammatory disease	epilepsy
nervous disorders	whiplash	other:

Have you received care from any of the following: (circle)

Physiotherapist Chiropractor Massage therapist Naturopath

Other: _____

Reason for treatment: _____

Number/duration of treatments: _____

Have you had surgery in the past? Y N If yes, for what? _____

Have you had any fractures/sprains in the past? Y N If yes, where? _____

Have you had any serious illnesses in the past? Y N If yes, what? _____

Did the current injury result from a motor vehicle accident or workplace injury? Y N

Have you had any of the following regarding your current condition: (circle)

Physician's examination X-ray Other diagnostic tests

What relieves your pain? _____

What aggravates your pain? _____

Signature of Patient (or Guardian): _____