# Massage Therapy Patient Registration Form

## Patient Information

First Name: _____ Last Name: _____

Date of Birth: MO___ Day___ YR___ Gender: Female ( ), Male ( ), Other: _____

Address: _____ City: _____ Postal Code: _____

Tel: (H) _____ (W) _____ (C) _____

Email: _____ (appointment reminders only)

Emergency Contact Name: _____ Tel: _____

Family Physician: _____ Referring Source: _____

Occupation: _____

## Patient Medical History

CARDIOVASCULAR
- ❑ High blood pressure
- ❑ Low blood pressure
- ❑ Chronic congestive heart failure
- ❑ Heart attack
- ❑ Phlebitis/ varicose veins
- ❑ Stroke/ CVA
- ❑ Pacemaker or similar devices
- ❑ Heart disease

RESPIRATORY
- ❑ Chronic cough
- ❑ Shortness of breath
- ❑ Asthma
- ❑ Bronchitis
- ❑ Emphysema

MUSCULOSKELETAL
- ❑ Limited movement
- ❑ Fracture
- ❑ Arthritis
- ❑ Osteoporosis
- ❑ Tendonitis
- ❑ Sprains/strains
- ❑ Numbness/ tingling/ loss of sensation

HEAD AND NECK
- ❑ History of headaches
- ❑ History of migraines
- ❑ Vision loss
- ❑ Hearing loss
- ❑ TMJ dysfunction
- ❑ Vertigo/ dizziness

OTHER
- ❑ Diabetes
- ❑ Cancer
- ❑ Epilepsy
- ❑ Skin conditions
- ❑ Diabetes
- ❑ Allergies

INFECTIONS
- ❑ Hepatitis
- ❑ Skin conditions
- ❑ TB
- ❑ HIV/AIDS
- ❑ Herpes

FEMALES
- ❑ Pregnant Due Date: _____
- ❑ Possible chance of pregnancy

ALTERNATIVE HEALTH CARE
- ❑ Physiotherapy
- ❑ Chiropractic
- ❑ Naturopathy
- ❑ Other: _____

Please specify any other medical conditions that are not listed: _____

List of current medications: _____

List of past surgeries and hospitalizations (with dates): _____

List of past accidents and injuries (with dates): _____

What is the reason you are seeking massage therapy? Please include the location of any tissue or joint discomfort.

_____

Do you have any internal pins, wires, artificial joints, special equipment etc.? _____

# Massage Therapy Consent Form

I understand that the purpose of massage therapy is to restore and maintain the integrity of the musculoskeletal system. I am aware that massage therapy is a hands-on health care discipline that will require the massage therapist to place his/her hands on those areas of the body that are involved in the cause of my symptoms. I am aware my massage therapist is a Regulated Health Care Professional and has the right to discontinue the treatment at their discretion.

I understand that massage therapists assess and do not diagnose illnesses, disease or any physical or mental disorders; nor do they prescribe medical treatment, pharmaceuticals, or perform spinal manipulations. Therefore, I acknowledge that massage therapy is not a substitute for a medical examination or diagnosis, and it is recommended that I see a primary health care provider for this service.

I acknowledge that in the practice of massage therapy there is the potential for mild side effects, including, but not limited to muscle soreness/tenderness in the area worked on (the day of or the day after), and mild bruising. Following the treatment, dizziness can occur after lying face down for a long period of time and feelings of fatigue are common. I understand that some massage techniques are aimed to increase circulation that can alter my blood pressure, and therefore all circulatory conditions are to be disclosed to the treating massage therapist.

Massage therapy is known to be effective for headaches, soft tissue and joint injuries, and your overall well-being. The risk of injuries or complications from massage therapy is substantially lower than that associated with many medical or other treatments, medications, and procedures given for the same symptoms.

I understand that I have the right to modify or discontinue the treatment at any time.

**I further understand that cancelling my appointment without 24-hour notice may be subjected to 50% of the appointment fee for my appointment.** However, under the discretion of the treating massage therapist where certain circumstances may apply, this fee may be waived.

I consent to the massage therapy offered or recommended to me by my registered massage therapist and this applies to all present and future massage therapy treatments.

I, _____ (print your name), have read and acknowledged all the above information and give my consent for massage treatment/assessment.

Signature: _____ Date: _____

Please note the information provided on these forms will assist us in treating you safely and effectively. All information provided on these forms will be kept confidential unless allowed or requested by law. Your written permission will be required to release any information. If your health status changes, please let us know. If you have any questions regarding your visit, do not hesitate to ask!

MSKcentre
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