February 2018 MASSAGE THERAPY

Name: ______________________________

Date: ______________________________

AHC #: ______________________________

Email Address: ______________________________

Under Canada's new anti-spam legislation, we are required to ask you for your consent to send you email reminders and information regarding your health.
Do you consent? ______ (YES) _____(NO) ______________________
Sign or Initial here

******RECENT CHANGES TO THE INSURANCE INDUSTRY MAY HAVE AFFECTED YOUR ELIGIBILITY TO BE REIMBURSED FOR MASSAGE. IT IS YOUR RESPONSIBILITY TO KNOW YOUR POLICY. IF YOUR INSURANCE POLICY REQUIRES A THERAPIST WITH A CERTAIN LEVEL OF QUALIFICATION YOU MUST DISCLOSE THAT INFORMATION AT TIME OF BOOKING YOUR MASSAGE******

Why This Form Is Important

As a full spectrum Chiropractic office, we focus on your ability to be healthy. Our goals are, first, to address the issues that brought you to this office, and second, to offer you the opportunity of improved health potential and wellness services in the future. On a daily basis we experience physical, chemical and emotional stress that can accumulate and result in serious loss of health potential. Most times the effects are gradual, not even felt until they become serious. Answering the following questions will provide a profile of the specific stresses you have faced in your lifetime, allowing us to better assess the challenges to your health potential. **Please be aware that our massage appointments are comprehensive. ***Change time and consultation time are included within your designated appointment time.*****

People see Muscle Therapists for a variety of reasons. Some go for relief of pain, some to correct the cause of pain and others for correction of whatever is malfunctioning in their bodies. Your Therapist will weigh your needs and desires when recommending your treatment program. Please check the type of care desired so that we may be guided by your wishes whenever possible.

- ☐ Relief Care – Symptomatic relief of pain or discomfort
- ☐ Corrective Care – Corrective and relieving the cause of the problem as well as the symptoms
- ☐ Comprehensive Care – Bring whatever is malfunctioning in the body to the highest state of health possible with muscle therapy
- ☐ I want the Doctor to select the type of care appropriate for my condition

NAME:______________________ **M/F (CIRCLE) DATE:** ______________

ADDRESS/CITY/PROV: ______________________ **POSTAL CODE:** ______________

HOME PHONE: ______________ **CELL PHONE:** ______________ **BUS. PHONE:** ______________

EMAIL: ______________________ **DATE OF BIRTH (M/D/Y):** ______________ **AGE:** ______

OCCUPATION: ______________________

NAME OF SPOUSE: ______________________ **CHILDREN? Y/N HOW MANY?:** ________

WHO CAN WE THANK FOR REFERRING YOU? ❑ NAME: ______________________

❑ WALK BY ❑ IN-HOUSE/BEACON HILL STAFF ❑ WEBSITE ❑ OTHER: ______________

EMERGENCY CONTACT NAME: ______________________ **PHONE NUMBER:** ______________

IF UNDER 18, NAME OF PARENTS: ______________________

HEALTH CONDITIONS/HABITS (CHECK THOSE WHICH APPLY):

❑ CIRCULATORY PROBLEMS ❑ HIGH/LOW BLOOD PRESSUE ❑ HEART CONDITIONS ❑ VARICOSE VEINS

❑ SEIZURES ❑ STRESS ❑ INSOMNIA ❑ HEADACHES/MIGRAINES

❑ MENTAL HEALTH CONCERN ________________ ❑ DIABETES ❑ DIGESTIVE ISSUES

❑ ALLERGIES (LIST) ____

❑ ASTHMA ❑ SKIN PROBLEMS ❑ ARTHRITIS ❑ FRACTURES/PLATES/PINS ❑ NERVE DAMAGE

❑ SPRAIN/STRAIN __________________________ ❑ INFLAMMATION ❑ MUSCLE TENSION

❑ BACK PAIN ❑ NECK PAIN ❑ TRAUMA/FALLS ❑ WHIPLASH ❑ TMJ SYNDROME

❑ TUMOURS/CANCER ____________________ ❑ CONTAGIOUS DISEASE ❑ LUNG DISEASE

❑ KIDNEY DISEASE ❑ PREGNANT: DUE DATE ___________________ ❑ NEW MOTHER

❑ NURSING ❑ MENOPAUSE ❑ OTHER: ______________________________________

❑ SMOKER: NUMBER PER DAY? ______ ❑ ALCOHOL Y/N ❑ WATER: CUPS PER DAY____ ❑ CAFFEINE INTAKE ______________

SUGAR INTAKE: MINIMAL/MODERATE/SIGNIFICANT DO YOU WEAR CONTACT LENSES Y/N DO YOU HAVE AN IUD Y/N

EXERCISE HABITS: SEDENTARY/MODERATE/ACTIVE ______________________________________

FAMILY HISTORY OF: ❑ ARTHRITIS ❑ HEART DISEASE ❑ DIABETES ❑ HIGH BLOOD PRESSUE ❑ CANCER

PLEASE LIST ALL SURGERIES/FALLS/ACCIDENTS AND THEIR DATES: ______________________________

____

WHAT DO YOU HOPE TO ACCOMPLISH WITH MASSAGE THERAPY?

❑ MVA AREAS AFFECTED: ______________________________________

❑ RELAXATION ❑ DEEP TISSUE THERAPY ❑ TREATMENT FOR: ______________________________

____

WHAT HAVE YOU TRIED FOR RELIEF? ❑ HEAT ❑ COLD ❑ EXERCISE/STRETCHING

❑ PHYSIOTHERAPY ❑ MASSAGE THERAPY ❑ CHIROPRACTIC ❑ OTHER ____________________

ARE YOU CURRENTLY UNDER A PHYSICIAN'S CARE? YES/NO

WHY? ____

PLEASE LIST ALL MEDICATIONS: ______________________________

PAIN/DISCOMFORT DIAGRAM:

Instructions: Mark these drawings according to where you hurt (if the right side of your neck hurts, mark the drawing on the right side of the neck, etc.). Please indicate which sensations you feel by referring to the key below.

☐ RIGHT HANDED

☐ LEFT HANDED

KEY	
//////	Stabbing
XXXX	Burning
0000	Pins & Needles
====	Numbness
++++	Aching

PAIN LEVEL	
0	No pain
1	Mild pain; you are aware of it but it doesn't bother you
2	Moderate pain that you can tolerate without medication
3	Moderate pain that requires medication to tolerate
4-5	More severe pain; you begin to feel antisocial
6	Severe pain
7-9	Intensely severe pain
10	Most severe pain; it may make you contemplate suicide

Right Left Right

CIRCLE YOUR CURRENT PAIN LEVEL

0 1 2 3 4 5 6 7 8 9 10

TREATMENT PREFERENCES:

MUSIC: ☐ **NO PREFERENCE** ☐ **LIKE/PREFER:** ____________________ ☐ **DISLIKE:** ____________________

MASSAGE OIL: ☐ **NO PREFERENCE** ☐ **UNSCENTED** ☐ **SCENTED**

DO YOU ENJOY CONVERSATION DURING TREATMENT? ☐ **SOMETIMES** ☐ **YES** ☐ **NO**

ARE THERE AREAS OF YOUR BODY THAT YOU PREFER NOT TO BE MASSAGED?

☐ **FEET** ☐ **HEAD** ☐ **OTHER:** ______________________________

<u>*PLEASE COMMUNICATE YOUR PRESSURE AND COMFORT PREFERENCE WITH YOUR THERAPIST DURING EACH MASSAGE.***</u>**

PLEASE READ AND SIGN:

THIS AGREEMENT AND THE CONTENTS OF THIS FILE ARE CONFIDENTIAL. THE DATA WILL NOT BE SHARED OUTSIDE OF BEACON HILL CHIROPRACTIC AND MASSAGE WITHOUT CLIENT PERMISSION.THE INFORMATION IS TO ASSIST THE THERAPISTS IN PROVIDING THE SAFEST AND MOST EFFECTIVE TREATMENT PLAN FOR YOU.

I understand that the massage therapist is providing massage therapy services within their scope of practice.

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. Risks include, but are not limited to, swelling, bruising, soreness, allergic reactions.

I acknowledge and understand that the therapist must be fully aware of my existing medical conditions. I have completed my medical history form 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 understand that the treatment of muscle therapy/ massage provided by the therapist when requested without a chiropractic preliminary exam/ assessment is separate and distinct from the practice of Chiropractic provided by the Doctors of Beacon Hill Chiropractic & Massage. I hereby waive all liability towards the above mentioned doctors directly or indirectly associated with Beacon Hill Chiropractic and Massage should any injury or malpractice occur from any treatment provided by the muscle/ massage therapist.

I have read the above noted consent and I have had the opportunity to question the contents and my therapist. 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.

I understand that payment is expected at the time of service AND that if I fail to cancel an appointment 24 hours in advance, or have missed an appointment, I will be charged the following cancellation fees:

First Time - Warning
Second Time - 100% of massage price

Patient Name: ________________________________ **Date:** ________________________________

Signature of Patient ____

Thank you for choosing the Beacon Hill Massage team to assist you with your healthcare goals.