Integrated Health & Wellness Centre

40 Wynford Drive, Suite 300, North York Ontario, M3C 1J5 (416) 445-1564

MASSAGE THERAPY - CONFIDENTIAL PATIENT CASE HISTORY

The information request below will assist us in treating you safely. Feel free to ask any questions about the information being requested.
Please note that all information provided below will be kept confidentially unless allowed or required by law. Your written permission will be required to release any information.

File _____ DATE _____

NAME _____ Sex ○ M ○ F Age_____

Home Address _____ CITY _____ POSTAL CODE _____

Home Phone _____ Business Phone _____ Ext ___Cellular _____

Date of Birth (M)_____ / (D)_____ / (Y)_____ E-mail _____

Occupation _____ Employed by _____ Full Time or Part Time

Your Medical Doctor _____

Do you or wife have Extended Health Care Benefits? _____ If Yes, with who? _____

Have you received massage therapy before? Y N
Did a health care practitioner refer you for massage? Y N
If yes, please provide their name and address _____

Please indicate conditions you are experiencing or have experienced

CARDIOVASCULAR
□ High Blood Pressure
□ Low Blood Pressure
□ Chronic Congestive Heart Failure
□ Heart Attack
□ Phlebitis / Varicose Veins
□ Pacemaker or Similar Device
□ Heart Disease

Is there a Family History of any of the above Y N

INFECTIONS
□ Hepatitis
□ Skin Conditions
□ TB
□ HIV
□ Herpes

HEAD / NECK
□ History of Headaches
□ History of Migraines
□ Vision Problems
□ Vision Loss
□ Ear Problems
□ Hearing Loss

WOMEN
□ Pregnant, due _____
□ Gynecological conditions_____

RESPIRATORY
□ Chronic Cough
□ Shortness of Breath
□ Bronchitis
□ Asthma
□ Emphysema

Is there a Family History of any of the above Y N

OTHER CONDITIONS
□ Loss Sensation, where?_____
□ Diabetes, Onset _____
□ Allergies/Hypersensitivity to what_____
Types of Reaction_____
□ Epilepsy
□ Cancer, Where?_____
□ Skin Conditions, What _____
□ Arthritis

Overall how is your health?_____ Primary Care Physician _____
Current Medication _____ Conditions it treats _____
Are you currently receiving treatment from another health care professional Y N _____
Surgery – date _____ Nature _____
Injury – date _____ Nature _____

Do you have any other medical conditions? (eg digestive conditions, haemophilia, osteoporosis, mental illness) Y N
What ? _____
Do you have any internal pins, wires, artificial joints or special equipment? Y N
What ? _____ Where ? _____
What is the reason you are seeking massage therapy? _____
Please include the location of any tissue or joint discomfort _____

Date of Initial Health History _____
Update 1 _____
Update 2

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May Azuzena RMT

WELCOME TO OUR OFFICE

We will do our best to provide you and your family with the best massage therapy care possible.
However, there are a few things you and your family can do to help us.

APPOINTMENT(S) / CANCELLATION(S) / LATE / NO SHOWS

1. A specific course of care has been designed for you by our Centre.
2. The appointment time is RESERVED for you.
3. If you are unable to keep this time, please cancel YOUR scheduled appointment within **24 hours**
4. Missed appointment(s) will be charged
5. Please be **ON TIME** for your appointment(s) to avoid any unnecessary delays
6. We respect our patient's time and try to see them promptly.
7. If you are late, this inconveniences the patient coming after you.
8. Please try not to be late for YOUR scheduled appointment(s), which was specifically RESERVED for you.
9. If you are running late, please call us so we can decide if we still can see you.
10. Payments is to be made the time of treatment

I hereby agree to all of the 10 points as listed and indicated above **___ Initial**

INFORMED CONSENT FOR MASSAGE TREATMENT

I, the undersigned do here by acknowledge:

- My understanding that any massage and/treatments techniques will be explained to me with benefits and risks before use, so that I can make an informed decision to follow the therapist's treatment plan.
- My obligation to immediately inform the therapist of any pain, discomfort, fatigue or any other symptoms that I may suffer during and immediately after treatment.
- My understanding that I may stop or delay any further treatment if I so desire and that the treatment may be terminated by the therapist upon observation of any symptoms of distress or abnormal response.
- My understanding that I may ask any questions or request further explanation or information about the procedures at any time before, during and after treatment.

I have read and **FULLY UNDERSTAND** the content and intention of this consent and sign willingly.

Dated this _____ day of _____, 20_____.

_____ _____

Patient Name (please print) **Witness Name (please print)**

_____ _____

Patient Signature (Legal Guardian) **Witness of Signature**

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MASSAGE THERAPY OFFICE PROCEDURE CONSENT

Please read carefully and thoroughly

I hereby request and consent to massage therapy soft-tissue procedures. I have discussed with a therapist and/or with other office or clinic personnel the nature and purposes of therapeutic massage and other related procedures. I understand that results will vary depending on the individual and the extent of their condition.

I understand and am informed that, as in all health care procedures there are some risks to treatment which if applicable, will be discussed before treatment. I wish to rely on the therapist to exercise judgment during the course of treatment based upon facts then known.

At Integrated Health & Wellness Centre, we value you as a patient. We strive to provide a relaxing, educating, and healthy atmosphere. Our therapist treats everyone with respect and trust, and so deserves the same in return. The therapist works a limited number of hours each week to ensure the best possible care. Under these conditions, the Centre must reserve the right to charge the full fee for a missed appointment with less than twenty-four (24) hours' notice. Also, the right is reserved by the Centre to charge the full schedule fee for tardiness or appointments', and/or request that appointments are secured by VISA or MasterCard.

Massage Therapy Fee Schedule:

Time	Cost	HST	Total
30 Mins Massage	$55	$ 7.15	**$ 62.15**
45 Mins Massage	$70	$ 9.10	**$ 79.10**
60 Mins Massage	$80	$ 10.40	**$ 90.40**
90 Mins Massage	$120	$ 15.60	**$ 135.60**

MASSAGE THERAPY DECLARATION AND CONSENT TO TREATMENT

Patient's Name: _____

It is my choice to receive massage therapy. I realize that treatment is being given for the well-being of my mind and body. This includes stress reduction, relief from muscular tension, spasms or pain or increasing circulation or energy flow. I agree to communicate with my massage therapist any time that I feel my well-being is being compromised.

I understand that massage therapist do no diagnose illness, disease, or any physical or mental disorder, nor do they prescribe medical treatment, pharmaceuticals or perform spinal thrust manipulations. I acknowledge that massage is not a substitute for medical examination or diagnosis, and that it is recommended that I see a health care provider for those services.

I hereby AUTHORIZE and CONSENT to TREATEMENTS and the FEE Schedule by a Registered Massage Therapist working at Integrated Health & Wellness Centre. I have read and **FULLY UNDERSTAND** the content and intention of this consent, massage therapy fee schedule and sign willingly.

Dated this _____ day of _____, 20_____.

_____ _____

Patient Name (please print) **Witness Name (please print)**

_____ _____

Patient Signature (Legal Guardian) **Witness of Signature**