

Digestive / Urinary			Cardiovascular		
Current	Previous		Current	Previous	
<input type="checkbox"/>	<input type="checkbox"/>	Constipation	<input type="checkbox"/>	<input type="checkbox"/>	High Blood Pressure ____ / ____
<input type="checkbox"/>	<input type="checkbox"/>	Diarrhea	<input type="checkbox"/>	<input type="checkbox"/>	Low Blood Pressure ____ / ____
<input type="checkbox"/>	<input type="checkbox"/>	Crohn's Disease	<input type="checkbox"/>	<input type="checkbox"/>	Heart Attack
<input type="checkbox"/>	<input type="checkbox"/>	Irritable Bowl Syndrome	<input type="checkbox"/>	<input type="checkbox"/>	Chronic Congestive Heart Failure
<input type="checkbox"/>	<input type="checkbox"/>	Ulcer	<input type="checkbox"/>	<input type="checkbox"/>	Chest Pain / Angina
<input type="checkbox"/>	<input type="checkbox"/>	Diverticulitis	<input type="checkbox"/>	<input type="checkbox"/>	Stroke
<input type="checkbox"/>	<input type="checkbox"/>	Nausea	<input type="checkbox"/>	<input type="checkbox"/>	Pace Maker
<input type="checkbox"/>	<input type="checkbox"/>	Liver / Gall Bladder	<input type="checkbox"/>	<input type="checkbox"/>	Phlebitis
<input type="checkbox"/>	<input type="checkbox"/>	Kidney / Bladder	<input type="checkbox"/>	<input type="checkbox"/>	Hemophilia
<input type="checkbox"/>	<input type="checkbox"/>	Urinary Tract Infection	<input type="checkbox"/>	<input type="checkbox"/>	Heart Disease
<input type="checkbox"/>	<input type="checkbox"/>	Other:	<input type="checkbox"/>	<input type="checkbox"/>	Varicose Veins
<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>	Other:
Nervous System			Infections		
Current	Previous		Current	Previous	
<input type="checkbox"/>	<input type="checkbox"/>	Spinal Cord Injury	<input type="checkbox"/>	<input type="checkbox"/>	Hepatitis
<input type="checkbox"/>	<input type="checkbox"/>	Numbness / Tingling			Type:
<input type="checkbox"/>	<input type="checkbox"/>	Sensory Change / Loss	<input type="checkbox"/>	<input type="checkbox"/>	Infectious Skin Condition(s)
<input type="checkbox"/>	<input type="checkbox"/>	Sciatica	<input type="checkbox"/>	<input type="checkbox"/>	TB
<input type="checkbox"/>	<input type="checkbox"/>	Thoracic Outlet Syndrome	<input type="checkbox"/>	<input type="checkbox"/>	HIV / Aids
<input type="checkbox"/>	<input type="checkbox"/>	Seizures	<input type="checkbox"/>	<input type="checkbox"/>	Other:
<input type="checkbox"/>	<input type="checkbox"/>	Multiple Sclerosis			
<input type="checkbox"/>	<input type="checkbox"/>	Cerebral Palsy	Disease / Condition		
<input type="checkbox"/>	<input type="checkbox"/>	Epilepsy	Current	Previous	
<input type="checkbox"/>	<input type="checkbox"/>	Carpal Tunnel	<input type="checkbox"/>	<input type="checkbox"/>	Cancer benign / malignant
<input type="checkbox"/>	<input type="checkbox"/>	Muscular Dystrophy			Type / Location:
<input type="checkbox"/>	<input type="checkbox"/>	Other:			Treatment:
			<input type="checkbox"/>	<input type="checkbox"/>	Fibromyalgia
			<input type="checkbox"/>	<input type="checkbox"/>	Chronic Fatigue Syndrome
			<input type="checkbox"/>	<input type="checkbox"/>	Allergies (anaphylaxis, seasonal etc.)
					Diabetes
					Type:
					Onset:
			<input type="checkbox"/>	<input type="checkbox"/>	Other:
Skin			Bone / Joint		
Current	Previous		Current	Previous	
<input type="checkbox"/>	<input type="checkbox"/>	Eczema	<input type="checkbox"/>	<input type="checkbox"/>	Dislocation
<input type="checkbox"/>	<input type="checkbox"/>	Dermatitis	<input type="checkbox"/>	<input type="checkbox"/>	Fracture
<input type="checkbox"/>	<input type="checkbox"/>	Acne	<input type="checkbox"/>	<input type="checkbox"/>	Arthritis (RA / OA)
<input type="checkbox"/>	<input type="checkbox"/>	Frostbite	<input type="checkbox"/>	<input type="checkbox"/>	Degenerative Disc Disease
<input type="checkbox"/>	<input type="checkbox"/>	Psoriasis	<input type="checkbox"/>	<input type="checkbox"/>	Prolapsed / Herniated Disc
<input type="checkbox"/>	<input type="checkbox"/>	Sensitive Skin	<input type="checkbox"/>	<input type="checkbox"/>	Other:
<input type="checkbox"/>	<input type="checkbox"/>	Rash / eruptions			
<input type="checkbox"/>	<input type="checkbox"/>	Cold Sores			
<input type="checkbox"/>	<input type="checkbox"/>	Herpes			
<input type="checkbox"/>	<input type="checkbox"/>	Plantar Warts			
<input type="checkbox"/>	<input type="checkbox"/>	Bruise Easily			
<input type="checkbox"/>	<input type="checkbox"/>	Other:			
Soft Tissue Joint Discomfort and / or Pain			Women Only		
Current	Previous		Current	Previous	
<input type="checkbox"/>	<input type="checkbox"/>	Neck	<input type="checkbox"/>	<input type="checkbox"/>	Pregnancy
<input type="checkbox"/>	<input type="checkbox"/>	Shoulder / Arm	<input type="checkbox"/>	<input type="checkbox"/>	Vaginal Birth / Abortion
<input type="checkbox"/>	<input type="checkbox"/>	Wrist / Hand			Number of Children _____
<input type="checkbox"/>	<input type="checkbox"/>	Back	<input type="checkbox"/>	<input type="checkbox"/>	Current Obstetrical Condition:
<input type="checkbox"/>	<input type="checkbox"/>	Hips	<input type="checkbox"/>	<input type="checkbox"/>	Other:
<input type="checkbox"/>	<input type="checkbox"/>	Legs			
<input type="checkbox"/>	<input type="checkbox"/>	Knees	Special Notes / Conditions		
<input type="checkbox"/>	<input type="checkbox"/>	Feet	(pins / wires / plates / artificial joints etc.)		
<input type="checkbox"/>	<input type="checkbox"/>	Poor Posture			
<input type="checkbox"/>	<input type="checkbox"/>	Strain / Sprain			
<input type="checkbox"/>	<input type="checkbox"/>	Tendonitis			
<input type="checkbox"/>	<input type="checkbox"/>	Other:			

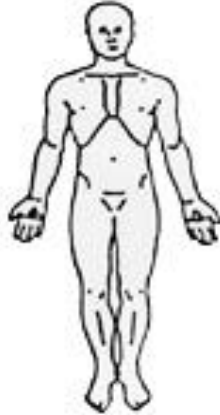
TREATMENT OPTIONS

Please list any areas you DO NOT want treated:

PLEASE CIRCLE THE SYMPTOMATIC AREAS YOU WOULD LIKE TREATED.



Left



Front



Back



Right

*** IMPORTANT**

An accurate health history is very important, and it ensures that you will receive a safe massage therapy treatment. If anything changes with your health status or conditions in the future please advise your therapist. All information gathered by your therapist is strictly confidential except as required by law or to facilitate diagnosis (assessment) or treatment. You will be asked to give written consent for the authorization for any release of any of your information.

Today's Date: _____

Client's Signature: _____

Therapist's Signature: _____

Dana L. Otterman
Registered Massage Therapist

Informed Consent

Client's Name: _____ Date: _____

This record of consent will provide confidentiality in your file and is required before any treatment can be provided. Massage Therapy includes the assessment and treatment of soft tissues and joints of the body, by means of any, or some of, the following: soft tissue manipulations, joint mobilization, hydrotherapy, remedial exercise programs, and directed self-care programs.

PLEASE READ THE FOLLOWING AND CHECK IF FULLY UNDERSTOOD:

- All massage treatments, information, and records will be safe and will remain confidential.
- Client may refuse, modify or stop treatment at any time, regardless of prior consent.
- The credibility of each client is respected, therefore privacy for dressing and undressing will be confirmed. Removal of clothing is to the level of your comfort is most effective and proper draping will be provided to assure security and privacy. Only one body part (being treated) will be undraped at one time, thus leaving the remainder of the body fully draped and covered at all times.
- Being prompt is required for all scheduled appointment times. In the event of being late, the massage treatment may be cut short. Fees will be maintained as per the schedule.
- Fees are as outlined:
 - \$40.00 per 30 min Treatment
 - \$55.00 per 45 min Treatment
 - \$70.00 per 60 min Treatment
 - \$100.00 per 90 min Treatment

Cash, cheque, debit and VISA will be accepted for payment at the time of treatment. Receipts will be issued.

- Client must inform clinic 24 hours prior to cancelling a scheduled appointment, otherwise a \$30.00 fee will be charged for missed appointments.
- Therapists may refuse to treat any client or part of their body with just and reasonable cause.
- An assessment must be conducted and a treatment outline proposed before the commencement of treatment. If an assessment proves to be beyond the scope of practice of this clinic, an appropriate referral will be made to another health care provider.

I, _____, have read and understand the information outlined in this consent to be treated for the following complaints: _____.

Today's Date: _____

Client's Signature: _____

Therapist's Signature: _____

