Massage Therapy Medical History

Name: _____

Date of Birth: _____

Address: _____

Phone (H): _____

(W): _____

(C): _____

Email: * _____

Type of Work/Occupation _____

Referred by: _____

***Email and texts are use for confirmations, reminders and office communication.**

Reason for initail visit.

_____

_____

Are you under any medical supervision for anything other that the reason for your visit?
YES **NO** If yes, explain.

_____

Are you taking any medications or supplements? **YES** **NO** If yes, what kind(s)?

_____

Are you currently pregnant? **YES** **NO** If yes, how far along? _____

What type(s) of physical activity/exercise do you do weekly?

_____

_____

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Please check if you have/had any of the following conditions.

Cancer	_____	Stroke	_____
Diabetes	_____	Allergies, asthma	_____
Epilepsy	_____	Parkinson's disease	_____
HIV/AIDS	_____	Arthritis	_____
Multiple sclerosis	_____	Varicose veins, blood clots	_____
High or low blood pressure (circle)	_____	Heart disease	_____
Skin infection or rash	_____	Digestive problems	_____
Fibromyalgia	_____	Osteoporosis	_____
Headaches	_____		

List any other conditions not mentioned above.

_____

_____

Have you ever had surgery, been in a vehicle accident or had an injury from work, contact sports, falling or overuse? **YES NO**
If yes, please list all injuries and when they occured.

_____

_____

_____

Is this visit part of an SGI or WCB claim? (Circle)

ALL INFORMATION IS CONFIDENTIAL.

Please inform your therapist of any changes to this information.

Signature: _____

Date: _____

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Informed Consent For Massage Therapy

I understand the Massage Therapist is providing a massage therapy service within their scope of practice as defined by the Massage Therapy Association of Saskatchewan, Inc. (MTAS)

I hereby consent that my Therapist may treat me with massage therapy for the above noted purposes including assessments, examinations and techniques, in which my Therapist may recommend.

I acknowledge that the Therapist is not a physician and does not diagnose illness, disease, or any other physical or mental disorders. I clearly understand that massage therapy is not a substitute for a medical examination. It is recommended that I see my personal physician for any ailments that I may be experiencing. I acknowledge that no assurance or guarantee is provided to me as to the results of the treatments. I acknowledge that with any treatments, there can be risks and those risks will be explained to me by my Therapist during each visit and I assume those risks.

I acknowledge and understand 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 all medical conditions affecting me. It is my responsibility to keep my 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. (As stated in the contract between Therapist and SGI/WCB and Health Insurance Providers)

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

Name(printed): _____ Date: _____

Patient Signature: _____

Therapist Signature: _____

**** If under the age of 16, please have parent or guardian sign below.****

Parent or Guardian Signature: _____