MASSAGE THERAPY INFORMED CONSENT

I, _____, understand that massage therapy provided by **Samantha Aimesbury**, is intended to enhance relaxation, reduce pain caused by muscle tension, increase range of motion, improve circulation and offer a positive experience of touch. Any other intended purposes for massage therapy are specified below.

The general benefits of massage, possible massage contraindications and the treatment procedure have been explained to me. I understand that massage therapy is not a substitute for medical treatment or medications, and that it is recommended that I concurrently work with my Primary Caregiver for any condition I may have. I am aware that the massage therapist does not diagnose illness or disease, does not prescribe medications, and that spinal manipulations are not part of massage therapy.

I have informed the massage therapist of all my known physical conditions, medical conditions and medications, and I will keep the massage therapist updated on any changes.

I understand that there shall be no liability on the practitioner's part due to my forgetting to relay any pertinent information. If I experience any pain or discomfort during the session, I will immediately communicate that to the therapist so the treatment can be adjusted.

I am aware that the fees are as follows:

$ 80 for 60 min
$65.00 for 45 min
$ 50 for 30 min

I understand that there is a full visit fee for missed appointments without a 24 hrs notice.

I have reviewed the Privacy Policy regarding collection, use and disclosure of my personal information and I understand that steps have been taken to ensure my privacy. I understand how the Privacy Policy applies to me and I have had an opportunity to ask for clarification.

Client Name :_____

Clients Signature: _____ Date: _____

Health History Form

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

How did you hear about us? _____

Name: _____ Phone: _____ Email: _____

Address: _____ Postal Code: _____

Occupation: _____ Date of Birth: _____

Have you received massage therapy before? □ Yes □ No
Did a Health Care Practitioner refer you for massage therapy? □ Yes □ No
If YES, please provide 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
- □ Stroke/CVA
- □ Pacemaker or similar device
- □ Heart Disease

Is there a family history of any of the above? □ Yes □ No

Respiratory
- □ Chronic Cough
- □ Shortness of Breath
- □ Bronchitis
- □ Asthma
- □ Emphysema

Is there a family history of any of the Above? □ Yes □ No

Infections
- □ Hepatitis
- □ Skin Conditions
- □ TB
- □ HIV
- □ Herpes

Other Conditions
- □ Loss of Sensation, Where? _____ _____
- □ Diabetes, onset _____
- □ Allergies/Hypersensitivity to what? _____
  Type of reaction: _____
- □ Epilepsy _____ _____
- □ Cancer, where? _____
- □ Skin Conditions, What? _____
- □ Arthritis

Is there a family history of arthritis? □ Yes □ No

Head/Neck
- □ History of Headaches
- □ History of Migraines
- □ Vision Problems
- □ Vision Loss
- □ Ear Problems
- □ Hearing Loss

Women
- □ Pregnant, due _____
- □ Gynecological Conditions? What? _____ _____

Overall, how is your general health? _____

Primary Care Physician: _____

Address: _____ _____

Current Medications: _____

_____

Condition it treats: _____ _____
Are you currently receiving treatment from another health care professional? □ Yes □ No

If yes, for what? _____

Surgery date: _____ Nature: _____

Do you have any other medical conditions? (e.g. digestive conditions, haemophilia, Osteoporosis, mental illness)
□ Yes □ No

Do you have any internal pins, wires, artificial joints or special equipment?
□ Yes □ No

What? _____

Where? _____

What is the reason you are seeking massage therapy? _____

Please include the location of any tissue or joint discomfort . _____

Injury Date: _____ Nature: _____