Oakville Trafalgar Memorial Hospital
327 Reynolds Street
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Milton District Hospital
7030 Derry Road
Milton, ON L9T 7H6
Tel: (905) 876.7022 Fax: (905) 876.7005

All net proceeds support hospital programs.

Registered Massage Therapy Consent

In keeping with the Health Care Consent Act (1996) it is my choice to receive massage therapy treatments.

Therefore, I give consent for the Registered Massage Therapist,

_____ to carry out this treatment.

- I am aware that it is not necessary to remove all articles of clothing for treatment and I will remove clothing that I am only comfortable with removing.
- I am aware that I may experience possible side effects from the treatment, such as temporary discomfort within the muscles (24-72 hours post treatment), bruising and temporary dizziness.
- If I experience any pain or discomfort, I will immediately inform the therapist so that the pressure or methods can be adjusted to my comfort level.
- I can communicate with the therapist at any time that I feel that my well-being is being compromised
- I may terminate treatment at any point during the massage, at discretion and without reason
- Registered Massage Therapy should not be performed under certain medical conditions. I affirm that I have stated all my known medical conditions and answered all questions honestly.
- I agree to keep the Registered Massage Therapist updated as to any changes in my medical profile during the session and future sessions and understand that there shall be no liability on the Massage Therapist's part should I fail to do so.
- I understand that massage professionals do not diagnose illness or disease or perform any spinal manipulations, nor do they prescribe any medical treatments.
- I agree to give 24 hours notice to any appointment change, or I will be charged the full appointment time.
- I agree to the fees for the following sessions:
    - 30 min - $50.00
    - 45 min - $71.00
    - 60 min - $87.00

I _____ understand the procedure of Massage Therapy that I will be receiving, to treat presented condition(s).

Client Signature: _____Date: _____

Therapist Signature: _____Date: _____

Health History Form
Registered Massage Therapy

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.

Name: _____ Phone # _____
Address: _____
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 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
- ☐ 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: _____
- ☐ gynaecological 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: _____

Injury – date _____
nature: _____

Do you have any other medical conditions? (e.g. digestive conditions, haemophilia, osteoporosis, mental illness) ☐ Yes ☐ No
what? _____

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.
_____
_____
_____

Notes:
_____
_____
_____
_____

Date of initial Health History: _____
Update 1 _____
Update 2 _____
Update 3 _____
Update 4 _____