



**Massage Therapy, Chiropractic & Acupuncture**

Carolyn Blaskievich, RMT & Victoria Hunt, RMT

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Please be advised the following information is required to ensure the most effective care and treatment plan can be created for you. The information on this form will be held in the strictest of confidence and used only for treatment purposes. In accordance with provincial privacy legislation your consent must be obtained regarding the collection, use and disclosure of personal information (including health information). The purpose for collecting, using and disclosing this information is set out in the "Consent for Assessment and Treatment" form and in the CMTO Privacy Code (8 pg. Doc. Available for viewing upon request).

Name: \_\_\_\_\_ Email: \_\_\_\_\_

Address: \_\_\_\_\_ Postal Code \_\_\_\_\_

Phone Number: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Occupation: \_\_\_\_\_ Employer: \_\_\_\_\_ Phone# \_\_\_\_\_

How did you hear of the clinic? \_\_\_\_\_

Name and Address of Primary Care Physician \_\_\_\_\_

Did a health care practitioner refer you for massage therapy? Yes No

If yes, please provide their name and address. \_\_\_\_\_

Please list your current involvement with other health care practitioners. \_\_\_\_\_

Please list the current medications you are taking and the conditions they are treating.

Please list the timing and nature of any injuries or accidents. \_\_\_\_\_

Please list the timing and nature of any surgical procedures. \_\_\_\_\_

Do you have any internal pins, wires, artificial joints or special equipment?

Yes No

If yes, what is it and where is it in your body? \_\_\_\_\_

Overall, how is your general health? \_\_\_\_\_

What is your primary complaint? \_\_\_\_\_

What is the location and nature of your soft tissue and / or joint discomfort?

Do you have any loss of vision? Yes No If yes, to what degree?

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Do you have any loss of hearing? Yes No If yes, to what degree?

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Do you have any loss of sensation? Yes No If yes, to what degree?

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Do you have any cardiovascular insufficiencies including (please check any that apply):

- |   |   |
|---|---|
| <input type="checkbox"/> High blood pressure              | <input type="checkbox"/> Heart disease                        |
| <input type="checkbox"/> Low blood pressure               | <input type="checkbox"/> Phlebitis                            |
| <input type="checkbox"/> Pacemaker or similar device      | <input type="checkbox"/> Chronic congestive heart failure     |
| <input type="checkbox"/> History of myocardial infarction | <input type="checkbox"/> History of cerebro-vascular accident |
| <input type="checkbox"/> Other, please describe _____     |   |
- 

Do you have any respiratory insufficiencies including (please check any that apply):

- |   |                                     |
|---|-------------------------------------|
| <input type="checkbox"/> Chronic cough                | <input type="checkbox"/> Bronchitis |
| <input type="checkbox"/> Shortness of breath          | <input type="checkbox"/> Asthma     |
| <input type="checkbox"/> Emphysema                    |                                     |
| <input type="checkbox"/> Other, please describe _____ |                                     |
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Do you have any allergies or hypersensitivity's?

- Yes  No

If yes, what are they and is the response anaphylaxis or skin irritation?

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Do you have diabetes?  Yes  No

Do you have arthritis?  Yes  No

Do you have cancer?  Yes  No

Do you have epilepsy?  Yes  No

Do you have any infectious conditions such as tuberculosis, AIDS/HIV, hepatitis, influenza, SARS?

- Yes  No If yes, what?
- 
- 

Do you have any skin conditions?

- Yes  No If yes, what is it and is it infectious?
- 
- 

Do you have any digestive conditions?

- Yes  No If yes, what?
-

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Do you have any blood conditions?

- Yes  No If yes, what?

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Do you have any other medical conditions?

- Yes  No If yes, what?

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If you are female, please answer the following questions:

Are you pregnant?  Yes  No

If yes, how far along are you? \_\_\_\_\_

Do you have any genealogical conditions?

- Yes  No If yes, what?

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The information I've given is correct and I will inform the therapist of any changes.

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Name of Client or Guardian

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Date



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## Consent for Assessment and Treatment

I understand the purpose of an assessment is to determine if massage therapy is indicated for me. The nature and purpose of the assessment will be discussed and I will be given the opportunity to ask questions.

I will be informed of the proposed treatment plan and will be given the opportunity to ask questions. Prior to the treatment I will be informed of the area's which will be treated, the proper positioning, and draping on the table.

I understand I have the ability to refuse, alter or rescind consent at any time through out the treatment.

I have honestly answered the health history questions, and understand the importance of informing you of any change. I understand the nature and purpose of the Massage Therapy treatment and therefore give my consent to start treatment.

\_\_\_\_\_  
Signature of Client

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature of Guardian

\_\_\_\_\_  
Date