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Initial Consultation Massage Therapy

Name:

Residential address:

Email:

Mobile #:	**Home phone #:**	**Work #:**
D.O.B: / /	**Occupation:**	**Name of Health Fund:**

How were you introduced to our office?

Predominant working postures: standing / sitting/ driving/ walking/ bending/ twisting/ lifting/ pushing & pulling/ computer work / overhead work / awkward working postures

Predominant sleeping position? Back / Side / Stomach

Sleeping patterns? ______ **# of hours** Regular / Deep / Light / Disrupted

Please list your primary concerns or reasons for having massage therapy.
1.
2.
3.

What other care / treatment are you receiving for your health concerns / to improve your health?

What family history and / or previous conditions do we need to be aware of in the provision of your care?

What sports, exercise and / or recreational activities do you regularly participate in?

What traumas do we need to be aware of relating to the provision of your massage therapy?

List all medications taken:	**List all supplements taken:**
What known allergies do you have to skin products?	**What scent aversions do you have?**
What is your stress level? Low / Med / High	**Any chance you are pregnant?**

What goals are you most interested in?
- □ **Eliminating my pain and / or symptoms**
- □ **Stress relief / relaxation**
- □ **Specific extremity care (ankle/knee/shoulder etc)**
- □ **Breaking up scar tissue / unwinding tight muscles**
- □ **Relieving muscular tension and spasming**

Privacy Policy Statement

In accordance with the Privacy Act, all information relevant to your case is held in trust and confidence. Your consent is necessary to allow us to exchange information for proper and effective care. I herby consent to any massage therapists working at Chiropractic Central to share information with a co-treating practitioner as required.

Printed name: ____

Informed Consent to Remedial Massage

When performed by a qualified therapist, remedial massage is an effective and safe method of treatment. There are risks associated with any treatment and we are required by law to inform you of these. Please read the following carefully. If you have any questions our massage therapist will discuss them with you during your consultation. I hereby request and consent to the performance of a remedial massage by the therapists of Chiropractic Central. I have had the opportunity to discuss with my therapist the nature and purpose of massage. I understand that results are not guaranteed. I understand and I am informed that, in the practice of remedial massage there are some minimal risks including, and not limited to, muscle and joint soreness, muscle strain/spasm, joint sprains, fractures, disk injuries and an exacerbation and/or aggravation of my underlying condition. I have read the above and I have also had the opportunity to ask questions and have been given sufficient time to make a decision giving consent for care to proceed. I intend this consent form to cover the entire course of treatment for my present condition and for any other future condition(s) for which I seek treatment. I understand that I can withdraw my consent at any time in writing.

Patient's Signature *(Parent or guardian to sign if patient is under 18 years of age):*

Signature: ______________________________ Date: ________________