OLLY CHIROPRACTIC

Wellness Tel/

2 Marsellus Dr. #15 Barrie, ON L4N 0Y4 Tel/FAX: (705) 728-9999 info@hmchiropractic.ca barriechiropractor.ca

NO

## Massage Therapy Rates of Service:

1.5 hour massage- \$125.00, 1 hour massage- \$90.00,

45 minute massage- \$75.00, 30 minute massage- \$55.00 **Date:** Name: \_\_\_\_\_ Age: Home Phone#: ( \_\_ ) \_\_\_\_\_ Address: Province: Postal Code: City: E-Mail Address: May we have your permission to contact you via email?: (circle one) YES NO Occupation: Work Phone #: ( ) Employer: How did you hear about our clinic? **Health History:** Please indicate conditions you are experiencing, or have experienced: Other Conditions: Soft tissue/ joint discomfort & its nature Respiratory: loss of sensation chronic cough (ie: ache/ pains/ sprain): shortness of breath diabetes? Type & head/neck shoulders/arms\_\_\_\_ bronchitis onset: arthritis asthma \_\_upper back \_\_\_\_\_ family history of arthritis middle back emphysema \_\_epilepsy low back \_\_\_\_\_ family history of the above? \_\_cancer hips/legs allergies? List: Cardiovascular: knee s\_\_\_\_ \_high blood pressure \_\_fibromyalgia feet/ ankle \_\_\_\_\_ \_low blood pressure other CHF car accidents? Head/ Sensory: heart attack vision problems when? phlebitis vision loss \_stroke/ CVA ear problems Other Medical Conditions (eg: digestive pacemaker or hearing loss concerns, gynecological conditions, similar device headaches or migraine hemophilia, etc.) heart disease **Infections:** hepatitis Of Special Note: (artificial joints, internal Skin: \_\_ skin conditions/sensitivities skin pins, wires, special equipment): TΒ List: \_ HIV Are you receiving any other treatment? (ie: Women Other: chiropractic, naturopath?) yes, no, Pregnant? Due Please specify\_\_\_\_\_ Date \_\_\_\_ How is your overall health? Current Medication(s) Condition it treats \_\_\_\_Injuries\_\_\_\_\_ Surgeries Family Physician Phone #:

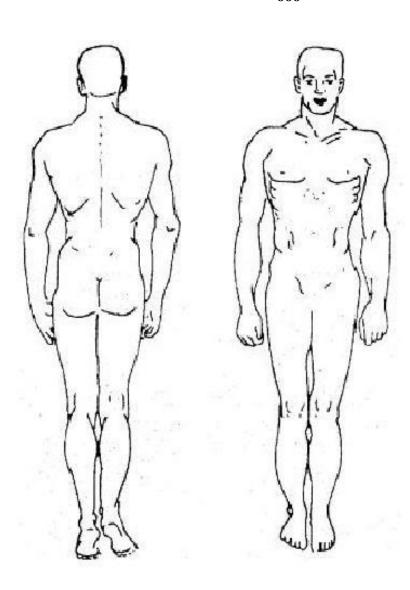
May we contact your Physician with regard to your massage treatment?

## **PAIN ASSESSMENT**

Patient Name	Date	

Using the diagrams below, please indicate the areas in which you are experiencing symptoms. Please indicate the type of pain/ discomfort using the appropriate symbols, and including all affected areas.

Numbness +++ Pins & Needles 000 000



## **CONSENT TO TREATMENT**

I hereby request and consent to the performance of therapeutic massage treatment, and other indicated modes of treatment including hydrotherapy, remedial exercise therapy, and home care instruction by the Registered Massage Therapist named below.

I have had the opportunity to discuss with the R.M.T. named below, the nature and purpose of these therapeutic treatments, their intended benefits and possible adverse effects. I understand treatment and draping procedure, and have been informed adequately regarding fee schedule and method of payment. I understand that I am responsible for service fees in full at the conclusion of each massage therapy treatment.

I understand that at any point in time, I may:

Date

- \*choose not to receive treatment on any given day
- \*discuss any potential modifications or alternatives
- \*discontinue or terminate treatment altogether

I have read the above consent. I have also had the opportunity to ask questions about its content, and by signing below, I agree to the above mentioned massage treatment.

	Hereby consent to the therapeutic massage treatment by
Print Patient Name	
	Registered Massage Therapist
Print R.M.T. Name	
Signature of Patient	