2 Marsellus Dr. #15
Barrie, ON
L4N 0Y4

Tel/FAX: (705) 728-9999
info@hmchiropractic.ca
barriechiropractor.ca

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: ________________________
Address: _______________________________Home Phone#: (__) ____________
Cell Phone #: (__) ________________________Date of Birth: _________________
City: ______________________Province: ___________Postal Code: ___________
E-Mail Address: ___________________________
May we have your permission to contact you via email?: (circle one) YES NO
Occupation: __________________________
Employer: __________________________Work Phone #: (__) _______________
How did you hear about our clinic? ____

Health History: Please indicate conditions you are experiencing, or have experienced:

Respiratory:
__chronic cough
__shortness of breath
__bronchitis
__asthma
__emphysema
__family history of the above?

Cardiovascular:
__high blood pressure
__low blood pressure
__CHF
__heart attack
__phlebitis
__stroke/ CVA
__pacemaker or similar device
__heart disease

Skin:
__ skin conditions/sensitivities
__List:___________________

Women
__Pregnant? Due Date______________________

Other Conditions:
__loss of sensation
__diabetes? Type & onset:______________________
__arthritis
__family history of arthritis
__epilepsy
__cancer
__allergies? List:____________
__fibromyalgia

Head/ Sensory:
__vision problems
__vision loss
__ear problems
__hearing loss
__headaches or __ migraine

Infections:
__hepatitis
__skin
__TB
__HIV
__Other:___________________

Soft tissue/ joint discomfort & its nature (ie: ache/ pains/ sprain):
__head/neck______________________
__shoulders/arms_________________
__upper back _____________________
__middle back ____________________
__low back _______________________
__hips/legs _______________________
__knee s_________________________
__feet/ ankle ______________________
__other __________________________
__car accidents?
when? _______________________

Other Medical Conditions (eg: digestive concerns, gynecological conditions, hemophilia, etc.)________________
____

Of Special Note: (artificial joints, internal pins, wires, special equipment):_____
____

Are you receiving any other treatment? (ie: chiropractic, naturopath?) ___yes, ___no, Please specify___________________

How is your overall health? ____
Current Medication(s) ___________________Condition it treats___________________
Surgeries_________________________________Injuries___________________________
Family Physician_________________________ Phone #:___________________________
May we contact your Physician with regard to your massage treatment? YES NO

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.

Dull Aching: XXX
XXX

Sharp Pain ///////
///////

Burning \\\\\\\\\\
\\\\\\\\\\

Numbness +++
+++

Pins & Needles **ooo**
ooo

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:

*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

______________________.
Date