13TH Ave Body & Soul Massage Therapy Health History Forms:

Name:_____

Phone(H)_____(W)_____(C)_____

Email:_____

Address:_____ Postal Code:_____

DOB:(Month)____(Day)_____(Year)_____

Employer:_____ Occupation:_____

How did you hear about us? _____

Reason for visit?_____ Referred By:_____

Have you had a Professional Massage before? Yes or No
Date of last Massage?_____

Trouble with Headaches? Yes or No How often? _____Migraines? Yes or No?

Have you been treated for any of the following:

Thyroid Problems Ulcers Heart Disease Lung Disease Cancer

Diabetes HIV/Immune Deficiency Alcoholism/Substance Abuse

Arthritis Fibromyalgia Liver Disorder/Hepatitis Blood Clots/Varicose Veins

Jaw/Ear Pain Headaches/Dizziness Circulation Problems Epilepsy

Osteoarthritis Osteoporosis Back/Neck Injury Pneumonia Asthma

Other:_____

List of Medications(Over the counter and Prescription):

Medication:_____ For what Condition:_____
Medication:_____ For what Condition:_____
Medication:_____ For what Condition:_____
Medication:_____ For what Condition:_____

Signature:_____ Date:_____

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CONSENT FORM FOR MASSAGE THERAPY TREATMENTS:

I understand that the Massage Therapist is providing Massage Therapy services within their scope of practice as defined by Massage Therapist Association Of Saskatchewan, Inc (MTAS).

I hereby consent to my Therapist to treat with Massage Therapy for the above noted purposes including any assessments, examinations, and techniques which may be recommended by my Therapist.

I acknowledge that the Therapist is not a physician and does not diagnose illness or disease or any other physical or mental disorder. I clearly understand that Massage Therapy is not a substitute for a medical examination. I acknowledge that no assurance or guarantee has been provided to me as to the results of the treatment. I acknowledge that with any treatment there can be risks and those risks have been explained to me and I assume those risks.

I acknowledge and understand that the Therapist must be fully aware of my existing medical conditions. I have completed my medical history form, as provided by my Therapist, and have disclosed to the Therapist all of those medical conditions affecting me. It is my responsibility to keep the Massage Therapist updated on my medical history. The information I have provided is true and complete to the best of my knowledge.

I authorize my Therapist to release or obtain information pertaining to my condition and or treatment to/from my other caregivers or third party payers.

I have read the above noted consent and have had the opportunity to question the contents and my therapy. By signing this form, I confirm my consent to treatment and intend this consent to cover the treatment discussed with me and such additional treatment as proposed by my Therapist from time to time, to deal with my physical condition and for which I have sought treatment. I understand that at any time I may withdraw my consent and treatment will be stopped.

** Your file will stay with 13TH Ave Body & Soul Massage Therapy in the event of the Therapist(Angie) moves or quits, you can request to have the file for your records**

Patient Signature:_____
Witness Signature:_____ Date:_____

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