

Welcome to your massage therapy

Here is useful information about what to expect on your first visit.

What is unique about my massage treatments?

This approach utilizes the best of soft tissue manipulation, cranio-sacral therapy, gentle joint manipulation, myofascial release, and visceral manipulation with the aim to rebalance and realign the whole body. It is based on the philosophy that the body will heal itself when obstructions to health are removed. The structure and function of your body is interconnected: problems in one organ affect other organ systems. Expert palpation skills will locate and identify each problem, and then an exceptional range of manual skills assists in relieving discomfort quickly. Together we will treat the cause to alleviate the symptoms. Hour long appointments are tailored to personal needs and preferences.

What Can You Expect On You First Visit?

Your first visit is used as an opportunity to assess your state by reviewing your medical history. Please be as thorough as you can when completing the confidential health history form. Then a complete assessment of body posture, balance and alignment will be performed. For your own comfort and privacy, it is recommended for men to wear shorts and for women to wear shorts and a sports bra during the treatment. You will be asked to perform a series of simple, pain-free movements. Once the health history and examination are complete, I will explain the findings and we will discuss the treatment for this visit as well as a recommended ongoing treatment plan.

How Long Will it Take to See Results?

Depending on the nature of the problem, people typically note significant improvements within 2 to 5 visits. In other cases, a more prolonged approach may be required. Usually, the treatments are administered once every one or two weeks. This allows the body to adapt to treatment. Once you have achieved the goals of your treatment we will formulate a maintenance strategy for your health to prevent the problems from occurring in the future.

Post Treatment Recommendations

After a treatment, it is not advisable to do any heavy lifting or carrying including heavy shopping, housework or strenuous exercise. Following the treatment, muscles are relaxed and joints have been stretched. Over-training yourself at this time, could aggravate your problem and do further damage. Instead, find opportunities to take frequent restful breaks as this encourages the body wisdom to find and maintain renewed balance. Some clients feel tired after treatment - in which case rest and plenty of water are advisable.

Massage Health History Form

An accurate health history is important to ensure that it is safe for you to receive an effective massage treatment. All information gathered for this treatment is confidential except as required or allowed by law or except to facilitate your treatment. You will be asked to provide a written authorization for release of any information.

Name: _____

Address: _____

City: _____ Province: _____ PostalCode: _____

Phone (H): _____ (Bus.): _____ (Cell) _____

E-mail: _____

Male: Female: Date of Birth: _____

Occupation: _____ Employed By: _____

Marital Status: _____ Number of children: _____

Emergency Contact: _____ Phone: _____ Relation: _____

Name of Medical Doctor: _____ Address: _____

How did you hear about us? Doctor Massage Therapist Website Friends Family
 Other: _____

Address of referring health practitioner: _____

Have you had massage before? Yes / No

Are you currently receiving other health care? Yes / No If yes, please specify:

Health Concerns

What are your main health concerns in order of importance to you?

Prescription Drugs

List all prescription drugs that you are currently taking. Indicate what the prescription is for and how long you have been on each medication

Medical History

List any surgery's and when they occurred:

List any fractures and when they occurred:

List any major accidents and when they occurred (including car accidents):

Have you ever been knocked unconscious or taken a significant blow to the head? Please circle:

Yes / No If Yes, please state when: _____

Please list any allergies that you have:

Visual Pain Rating Scale

Make a mark (/) along the line which you think represents your current level of pain

Nopainatall _____ As bad as it could be

Pain Diagram

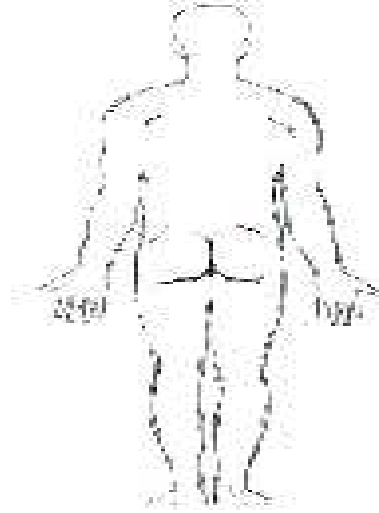
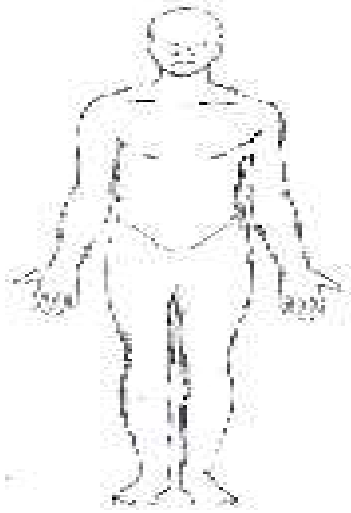
On the following diagrams, indicate all areas of:

Pain – xxxx

Stiness - ////

Numbness - 0000

Other (Specify)- _____



Medical History

In the lists below, check all the areas you are currently experiencing, and place a 'P' in the box of areas you have experienced in the past.

Please list if you have any artificial joints, pins, pacemakers, etc...:

General Symptoms

- Loss of Consciousness
- Blackouts
- Headaches
- Migraines
- Fever sweats
- Fainting
- Dizziness
- Convulsions / Seizures
- Loss of sleep
- Insomnia
- Chronic Fatigue
- Numbness, pain or tingling
- Nervousness / Anxiety
- Depression
- Loss of weight
- Hyperglycemia
- Hypoglycemia
- Hepatitis A / B / C
- Edema
- HIV Positive
- AIDS
- Cancer

Muscle and Joints

- Neck pain
- Upper back pain
- Mid back pain
- Low back pain
- Painful tailbone
- Shoulder pain
- Elbow pain
- Wrist pain
- Hand pain
- Hip pain
- Knee pain
- Ankle pain
- Foot pain
- Jaw pain
- Arthritis
- Family History of Arthritis

Eyes / Ears / Nose / Throat

- Blurred Vision
- Double Vision
- Eye pain
- Earache
- Loss of hearing
- Ringing / buzzing in ears
- Frequent colds / infections
- Enlarged glands / thyroid
- Speech problems
- Difficulty swallowing

Respiratory

- Asthma
- Allergies
- Sinus problems
- Emphysema
- Chronic cough
- Chest pain
- Difficulty breathing
- Bronchitis
- Pneumonia
- Pleurisy

Cardiovascular

- Difficulty breathing
- Shortness of breath
- Heart attack/myocardial infarction
- Anemia
- Stroke/cerebrovascular accident
- High blood pressure
- Low blood pressure
- Angina
- Hemophilia / bleeding disorder
- Circulation problems
- Varicose veins
- Hardening of arteries
- Swelling of ankles
- Poor circulation

Skin

- Rashes
- Itching
- Bruise easily
- Dryness
- Boils
- Hives (allergy)
- Eczema
- Psoriasis

Gastrointestinal

- Poor appetite
- Indigestion
- Ulcers
- Excessive hunger
- Belching or gas
- Nausea
- Vomiting
- Abdominal pain
- Constipation
- Diarrhea
- Hemorrhoids
- Jaundice
- Gall bladder problems
- Irritable bowel syndrome
- Colitis
- Crohns disease
- Celiac disease
- Hiatus hernia

Genitourinary

- Trouble urinating
- Blood in urine
- Kidney infection
- Prostate trouble
- Urinary tract infection

Female

- Painful menstruation / cramps
 - Excessive flow
 - Irregular cycle
 - Hot flashes
 - Vaginal discharge
 - Painful intercourse
- Menopausal* Y N
Pregnant Y N

Number of:

- pregnancies _____
- abortions _____
- miscarriages _____
- births _____

Male

- Prostate problem
- Impotence
- Pain
- Infertility/low sperm count
- STD
- Hernia

Agreement

I agree that it is my choice to receive massage treatment I understand that during the treatment the therapist will be open to any questions about procedure or effects as they occur. I understand that the whole external body excluding private areas may be treated. I agree to communicate with my therapist at any time if I feel like my well-being is being compromised.

I understand that massage therapists do not diagnose illness, disease or any physical or mental disorder, nor do they prescribe medical treatment or pharmaceuticals. I acknowledge that massage therapy is not a substitute for medical examination or diagnosis, and that it is recommended that I see a primary health care provider for that service.

I have stated all medical conditions that I am aware of and will update the therapist of any changes in my health status. I understand that this treatment is not covered by OHIP. The therapist is not responsible for any billing or dealings with private health insurance companies. However the receipt describing the details of the treatment as well as the therapist registration number will be issued.

Please read and initial that you have read the following:

I understand that I will be charged full price for missed appointments, appointment modifications or cancelled appointments if I do not provide at least 24 hour s advanced notice. Please initial here to show you have read and understood this billing agreement. Initials: _____

Signature

I attest that I have read the above information and that the information provided in this form is true and accurate to the best of my knowledge.

Signature: _____ Date: _____

