



in GoodHands

Rehabilitation & Wellness Centre

Inside GoodLife Fitness in Bramalea City Centre
Unit 50A - 25 Peel Centre Drive Brampton, ON L6T 3R5
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Website: www.ingoodhandswellness.com

Welcome

You are in GoodHands.

Date of Initial Health History: _____

Update 1 _____

Update 2 _____

Update 3 _____

Update 4 _____

MESSAGE THERAPY INTAKE FORM

HEALTH HISTORY

The information below will assist us in treating you safely. Feel free to ask any questions about the information being requested. Please note that all information provided below will be kept confidentially unless allowed or required by law. Your written permission will be required to release any information.

Name: _____ Phone #: () _____

Address: _____ City: _____ Province: _____ Postal Code: _____

Date of Birth: _____ Occupation: _____

Have you received massage therapy before? Y N

Did a health care practitioner refer you for massage therapy? Y N

If yes, please provide their name and address: _____

CURRENT HEALTH

Please indicate conditions you are experiencing or have experienced:

CARDIOVASCULAR

- high blood pressure
- low blood pressure
- chronic congestive heart failure
- heart attack
- phlebitis / varicose veins
- stroke / CVA
- pacemaker or similar device
- heart disease

Is there a history of any of the above?

Y N

RESPIRATORY

- chronic cough
- shortness of breath
- bronchitis
- asthma
- emphysema

Is there a family history of any of the above? Y N

INFECTIONS

- hepatitis
- skin conditions
- TB
- HIV
- herpes

OTHER CONDITIONS

- loss of sensation, where? _____
- diabetes, onset: _____
- allergies / hypersensitivity to what? _____

type of reaction: _____

- epilepsy
- cancer, where? _____
- skin conditions, what? _____

Is there a family history of arthritis?

Y N

HEAD / NECK

- history of headaches
- history of migraines
- vision problems
- vision loss
- ear problems
- hearing loss

WOMEN

- pregnant, due: _____
- gynecological conditions, what? _____

Overall, how is your general health? _____

Primary Care Physician: _____

Address: _____

Current Medications: _____

Condition it treats: _____

Are you currently receiving treatment from another health care

professional? Y N

If yes, for what? _____

Surgery – date: _____

Nature: _____

Injury – date: _____

Nature: _____

Do you have any other medical conditions? (e.g. Digestive conditions, haemophilia, osteoporosis, mental illness)

Y N

What? _____

Do you have any internal pins, wires, artificial joints or special equipment? Y N

What? _____

Where? _____

What is the reason you are seeking massage therapy?

Please include the location of any tissue or joint discomfort?

Please read and sign the following Informed Consent for treatment and office policy statement.

INFORMED CONSENT

I hereby consent to massage therapy treatment based on the following information:

- There are slight risks/side effects such as additional pain/slight inflammation. I will rely on the massage therapist's judgment to act in my best interests based on the current information I give.
- Massage therapy indications, risks and goals will be discussed.
- The treatment goals are not guaranteed.
- I understand that all information is confidential, unless I authorize release of information.
- I agree to update my file if there is any change in my medical status.
- I am aware that I can discontinue/change treatment at any time during the session.

PAYMENT SCHEDULE

The client is responsible for payment upon receiving the services. Please note that our office requires 24 hours notice of cancellation or there will be a charge of 50% of the scheduled treatment applied to your account. The appointment you have booked for treatment is reserved for you. If you are late for your appointment we are unable to extend the time beyond the appointment scheduled for you.

Fees: **90 minute massage \$110.00 (taxes included)**
 60 minute massage \$80.00 (taxes included)
 45 minute massage \$65.00 (taxes included)
 30 minute massage \$50.00 (taxes included)

I have read and understand the above information.

Print Full Name: _____ **Signature:** _____ **Date:** _____