

# Sinclair Wellness Centre

body, mind & spirit

## Massage Therapy Consent Form

Here at Sinclair Wellness Centre we only want to offer the best care for you. Please do not hesitate to book with a different RMT if you are not completely satisfied with your treatment.

### Acknowledgement and Consent:

The time allotted for your appointment includes time for an interview and assessment of your condition for the appropriate treatment. We make every effort to be on time for you and we ask that you extend the same courtesy. If you cannot keep your appointment please notify us immediately. Missed appointments and late cancellations (less than 24 hours in advance except in emergencies) are subject to the full cost of the treatment. \*\*\*INITIAL: \_\_\_\_\_

Name: \_\_\_\_\_ Date: \_\_\_\_\_

Address: \_\_\_\_\_

Contact (Wrk): \_\_\_\_\_ (Hm): \_\_\_\_\_

Occupation: \_\_\_\_\_ Birthdate: \_\_\_\_\_

Email: \_\_\_\_\_

Do you have extended health insurance? Yes  No

Are you presently involved in a litigation or a claim? Date of incident: \_\_\_\_\_

If yes, \_\_\_ ICBC \_\_\_ WCB \_\_\_ OTHER

Adjuster's name and contact #: \_\_\_\_\_

Please describe your primary concern today:

Onset of Problem: \_\_\_ Sudden \_\_\_ Gradual \_\_\_ Injury Date: \_\_\_\_\_

Degree of Pain: \_\_\_ Slight \_\_\_ Moderate \_\_\_ Severe

Are you receiving treatment from: \_\_\_ Chiropractor \_\_\_ Physiotherapist \_\_\_ Other

Do you smoke: \_\_\_ Yes \_\_\_ No

Are you taking any medications: \_\_\_ Yes \_\_\_ No

If yes, please indicate name of medication (if known) \_\_\_\_\_

please turn over...

Please rate your present stress level:    \_\_\_ Slight    \_\_\_ Moderate    \_\_\_ Severe

Is this usual for you?                    \_\_\_ Yes                    \_\_\_ No

List any activities you are experiencing difficulties with because of your present condition:

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### Patient's Medical History

	Past	Present		Past	Present
Abdominal Problems	___	___	HIV Positive	___	___
Allergies	___	___	Insomnia	___	___
Aneurysm	___	___	Jaw Pain	___	___
Arteriosclerosis	___	___	Kidney Condition	___	___
Arthritis	___	___	Menstrual Problems	___	___
Blood Clots	___	___	Neurological	___	___
Cancer	___	___	Conditions	___	___
Circulatory Conditions	___	___	Osteoporosis	___	___
Constant Irritability	___	___	Pregnancy	___	___
Diabetes	___	___	Respiratory	___	___
Dislocations	___	___	Conditions	___	___
Epilepsy	___	___	Seizures	___	___
Fainting	___	___	Skin Diseases/ Irritations	___	___
Frequent Colds or Flu	___	___	Spinal Injuries	___	___
Frequent Cold Hands or Feet	___	___	Stroke	___	___
Headaches	___	___	Surgery	___	___
Head Injury	___	___	Tumors or Cysts	___	___
Heart Problem	___	___	Unexplained	___	___
High or Low Blood Pressure	___	___	Weakness	___	___

Do you have:    \_\_\_ Implants    \_\_\_ Arch Supports    \_\_\_ Steel Pins    \_\_\_ Contact Lenses

I hereby acknowledge that I have read and answered the above to the best of my ability, and I request and consent to the treatment of massage therapy.

Signature \_\_\_\_\_

How did you hear about this clinic? \_\_\_\_\_

