arise Chiropractic

REGISTERED MASSAGE THERAPY

Name:
E-mail:
Work phone:
House phone:
Address:
DOB:
Gender:

PHN:
Insurance provider:
Emergency contact:
Emergency contact phone number:
Emergency contact relationship:
Family doctor (if known):
Family doctor phone number:
Occupation

Health History

Primary Reason for visit:

Please check all that apply:

- ☐ High blood pressure
- ☐ Low blood pressure
- ☐ Hyperthyroid
- ☐ Hypothyroid
- ☐ Varicose veins
- ☐ Seizures
- ☐ Headaches
- ☐ Migraines
- ☐ Diabete

Please check all that apply and give a brief explanation

- ☐ Fractures:
- ☐ Dislocations/Separations:
- ☐ Spinal injury:
- ☐ Sprains (that required intervention or rehabilitation):
- ☐ Head injury/concussions:
- ☐ Surgeries

Systemic conditions

Please check all that apply and give a brief explanation:

- ☐ Cardiovascular conditions:
- ☐ Respiratory condition:
- ☐ Digestive conditions:
- ☐ Liver conditions:
- ☐ Kidney conditions:
- ☐ Autoimmune conditions:
- ☐ Mental health conditions:
- ☐ Arthritis(specify type and location):
- ☐ Cancer/tumors:
- ☐ Skin conditions:
- ☐ Transplants:
- ☐ Numbness in limbs:
- ☐ Allergies:
- ☐ Pregnant:
- ☐ Other medical diagnoses:

List medication and supplements (dose and frequency):

Additional information:

Schedule A

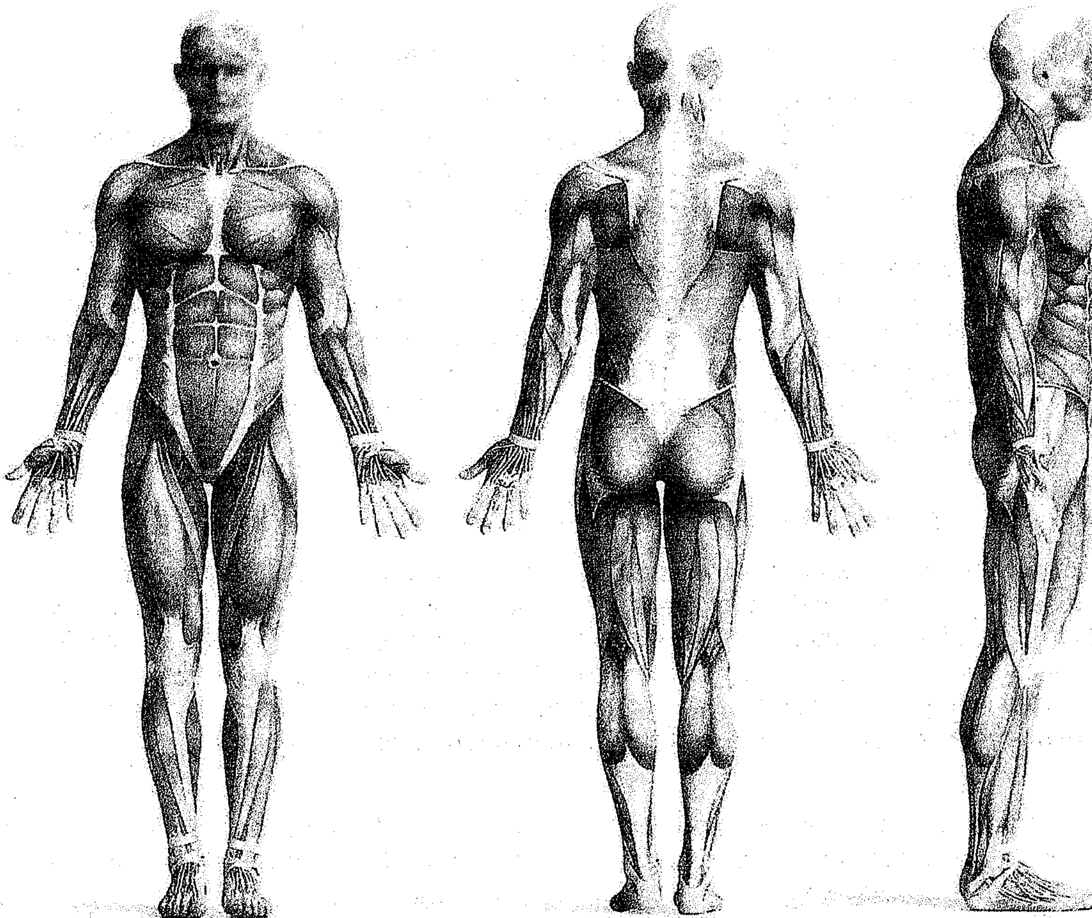
to Consent to Treatment of

(patient name) ______________________________

dated (dd/mm/yy) __/__/__.

Body Areas to be Treated:

I acknowledge and confirm that the areas of my body circled on the diagram below will be touched by the RMT during the course of my treatments:



I acknowledge and understand that it may be necessary for the RMT to adjust their treatment plan during my treatment, in which case they will discuss that with me.

Signature of Patient*: ________________________________ Date: (dd/mm/yy): ___/___/___

(* In the case of a person incapable of providing consent, signature of Parent or Guardian, in which case the

CONSENT TO TREATMENT

Therapist Name: Melanie Rodrigues RMT, Chris MacDonald RMT, Bill Richardson RMT, Jessica Decter RMT, Megan Surerus RMT

Patient Name:________________________________ DOB: (dd/mm/yy): ___/___/___

- **Read this document, <u>including Schedule "A"</u>, carefully and completely. It is important.**
- Please be sure to ask your RMT any questions you have about this form or its contents BEFORE you sign this document.
- You have the right <u>at any time</u> to ask questions about your treatment.
- Please be sure to immediately advise your RMT if you become uncomfortable with any aspect of your treatment, so that they may stop and discuss it with you.

The Treatment: I authorize and consent to the RMT performing the following specific treatments on me:

__ Soft Tissue Mobilization __Joint Mobilization __Exercise Therapy
__Other:____

Risks, Complications & Side Effects: I acknowledge and understand that:

- There are risks associated with any manual therapy techniques, including those techniques used by Registered Massage Therapists. Examples include bruising, aching, discomfort, short term aggravation of symptoms, muscle and ligament strains, sprains and skin irritation;
- **I have discussed any specific concerns I have about possible risks with my Therapist before signing this document**;
- The nature and purpose of the above treatments, the possible alternative methods of treatment, the risks involved and the possible complications and side effects have been fully explained to me by the RMT;
- I do not expect the RMT to be able to anticipate and explain all possible risks, complications and side effects of my treatment(s) to me; and
- I wish to rely on the RMT to exercise their judgment during the course of the treatment to provide the treatment that is in my best interests.

Disclosure of Medical History: I acknowledge and understand that:

- It is important for the RMT to know my medical history as it may relate to my treatment(s);
- I have disclosed to the RMT in writing all medical conditions, including any mental or emotional conditions for which I have received treatment, currently affecting me and those that have affected me in the past;
- I will immediately disclose in writing any medical condition that I subsequently realize I have not already disclosed, including any new condition that may develop after my completion of this form; and
- The information disclosed by me is true and complete to the best of my knowledge.

Confidentiality: The contents of this form and my patient records will be kept confidential unless I have expressly or impliedly consented to the release of my information or where there is a legal requirement to provide my information to a third party.

No Guarantee of Results: I acknowledge and confirm that no guarantee or assurance of results has been made to me regarding my treatments.

Signature of Patient*: ________________________________ Date: (dd/mm/yy): __/__/__

(* In the case of a person incapable of providing consent, signature of Parent or Guardian, in which case the Name & Relationship of Person Signing: ______________________________.)