A Balanced Approach Therapy Centre

'Healing Through Balance Through Therapy'

Name: _____ **Birth Date**_____ **Date**_____

Phone:_____ Emergency Contact:_____ Phone:_____

Whom may we thank for referring you?_____

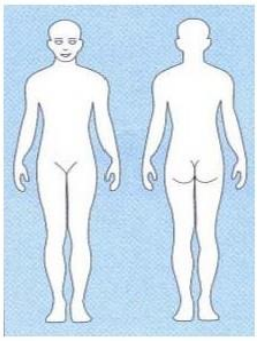
Email address: _____

Reason for Visit_____

When did your symptoms appear?_____

Is this condition getting progressively worse? ☐ Yes ☐ No ☐ Unknown

Mark an X on the picture where you continue to have pain, numbness, or tingling.



Rate the severity of your pain on a scale from 1 (least pain) to 10 (severe pain) ____

Type of pain: ☐ Sharp ☐ Dull ☐ Throbbing ☐ Numbness ☐ Aching

☐ Shooting ☐ Burning ☐ Tingling ☐ Cramps ☐ Stiffness ☐ Swelling Other:_____

How often do you have this pain?_____

Does it interfere with your: ☐ Work ☐ Sleep ☐ Daily Routine ☐ Recreation

What treatment have you already received for your condition? ☐ Medications ☐ Surgery ☐ Physical Therapy

☐ Chiropractic Services ☐ Massage Therapy ☐ None Other_____

Injuries/Surgeries	**Description**	**Date**
Falls:		
Head Injuries:		
Broken Bones:		
Surgeries:		
Birth Trauma/ Injury:		

Do you have any pins or plates? _____ If Yes, Where? _____

Medication(s)	Allergies	Vitamins/Herbs/Minerals

INFORMED CONSENT TO MASSAGE THERAPY TREATMENT

I understand that the Massage Therapist is providing massage therapy services within their scope of practice as defined by the Massage Therapist Association of Saskatchewan, Inc.

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

I acknowledge that the Massage 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. It is recommended that I attend my personal physician for any ailments that I may be experiencing. 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 Massage Therapist must be fully aware of my existing medical conditions. I have completed my medical history form as provided by my Massage Therapist and have disclosed to the Massage 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 Massage Therapist to release or obtain information pertaining to my conditions(s) and/or treatment to/from my other caregivers or third party payers.

I have read the above noted consent and I have had the opportunity to question the contents and my therapy. By signing this form, I confirm my consent and I 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 treatments as proposed by my Massage Therapist from time to time, to deal with my physical conditions and for which I have sought treatment. I understand that at anytime I may withdraw my consent and treatment will be stopped.

Patient Printed Name	Signature of Patient / Guardian
Massage Therapist	Date Signed