A Balanced Approach Therapy Centre

'Healing Through Balance Through Therapy'

Name _____ Birth Date _____ Today's Date _____

Address _____ Email _____

Street City Province Postal Code

Cell Phone (____) _____ Work (____) _____ Ext_____

Best time and place to reach you_____

CONTACT IN CASE OF EMERGENCY: _____ Relationship _____

Cell Phone (___) _____ Work (___) _____Ext_____

Whom may we thank for referring you? _____

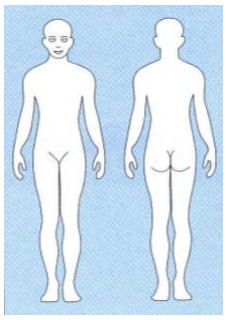
Would you like to receive our newsletter via email? □ Yes □ No

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?_____

Is it constant or does it come and go?_____

Activities or movements that are painful to perform □Sitting □Standing □Walking □Bending □Lying Down

Does it interfere with your □ Work □ Sleep □ Daily Routine □ Recreation

What treatment have you already received for your condition? □ Medications □ Surgery □ Physiotherapy
□ Chiropractic Services □ Massage Therapy □ None □ Other _____

Exercise: □ None □ Moderate □ Daily □ Heavy

Work Activity: □ Sitting □ Standing □ Light Labour □ Heavy Labour □ Mixed

Habits: □ Smoking Packs/day: _____ □ Alcohol Drinks/Week: _____

□ Coffee/Caffeine Cups/Day: _____ □ High Stress Level Reason_____

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**

(Please complete page 2)

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 have my Massage Therapist 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 that 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 any time I may withdraw my consent and treatment will be stopped.

_____	_____
Patient Printed Name	Signature of Patient / Guardian (to be signed at our office)
_____	_____
Massage Therapist	Date Signed