



220 Wexford Road, Unit 2 Brampton, ON L6Z 4N7 (905) 840-9355

Client Information

Name: _____ Date: _____
 Address: _____
 City: _____ Province: _____ Postal Code: _____
 Home Phone: _____ Business Phone: _____
 Cell Phone: _____ E-mail: _____
 Date of Birth: _____ Occupation: _____
 Physician's Name and Address: _____
 Emergency Contact (Name/Telephone): _____
 How did you hear about the Wellness Centre? _____

E.g. newspaper, friend, gift certificate, word of mouth, outside sign, etc.

Primary complaint: _____

Please indicate if you have any of the following conditions:

Head/Neck:

- headaches type: _____
- vision problems
- contact lenses
- head injury
- hearing problems
- earaches

Respiratory:

- chronic cough
- shortness of breath
- asthma
- emphysema
- sinus problems
- smoking
- heavy light
- bronchitis
- allergies

Cardiovascular:

- high blood pressure
- poor circulation
- heart disease
- pacemaker
- chronic congestive heart failure
- varicose veins (Dr. diagnosed)? _____
- low blood pressure
- phlebitis
- heart attack

Skin:

- sensitive skin
- plantar warts/athlete's foot
- eczema/psoriasis where? _____
- cold sores
- rashes
- bruise easily
- loss of sensation where? _____

Reproduction:

- Menstruation
 - painful
 - heavy
 - scant
- menopause
- pregnant due date: _____
- PMS

Infectious Conditions:

- tuberculosis
- hepatitis type: _____
- HIV/ AIDS

Of special note: e.g., pins, wires, artificial limbs, special equipment i.e. wheelchair, walker etc.

Muscle Strain:

- neck
- upper back
- mid back
- lower back
- shoulders
- arm/forearm
- hand
- abdomen
- thigh
- lower leg
- foot

Digestive/urinary:

- difficult digestion
- excessive appetite
- irritable bowel syndrome
- liver/gallbladder
- diabetes, type: _____ onset: _____
- poor appetite
- constipation
- ulcers
- Crohn's/colitis
- chronic diarrhea
- other: _____

Other Conditions:

- hemophilia
- fibromyalgia
- osteoporosis
- scoliosis
- cancer date: _____ type: _____
- herniated disc where? _____
- arthritis
- other: _____
- epilepsy
- carpal tunnel syndrome
- tendonitis
- bursitis
- family history of arthritis

Surgery/ Injury:

Type: _____
 Date: _____
 Type: _____
 Date: _____

Current medications and condition treated:

Previous massage experience	yes	no
Regular exercise	yes	no
Good sleeping patterns	yes	no
Physiotherapy	yes	no
Chiropractor	yes	no

I understand that the following information is confidential and correct to the best of my knowledge.

Signature: _____ Date: _____



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Consent to Assessment Process and Treatment

I, _____ (name), have requested assessment by this Registered Massage Therapist (RMT) and/or other JBWC Registered Massage Therapists. Following a discussion and review of assessment findings, I have requested treatment by this Registered Massage Therapist (RMT) and/or other JBWC Registered Massage Therapists for treatment of the areas identified below, for the purposes of treating the following clinical indications:

As part of my therapeutic assessment and treatment, I am aware that the RMT may touch the following area(s) of my body if needed and discussed and consented prior [client to place **initials** (not check marks) in relevant areas below]:

- | | | |
|--------------------------------------------------|-----------------------------------------------------|-----------------------------------------|
| <input type="checkbox"/> All areas needed | <input type="checkbox"/> Breast(s) | <input type="checkbox"/> Inner Thigh(s) |
| <input type="checkbox"/> Neck | <input type="checkbox"/> Chest Wall Muscles | <input type="checkbox"/> Legs |
| <input type="checkbox"/> Shoulders | <input type="checkbox"/> Back | <input type="checkbox"/> Feet |
| <input type="checkbox"/> Arms | <input type="checkbox"/> Buttocks (gluteal muscles) | |

The RMT has explained the following to me and I fully understand the proposed assessment and treatment including [client to place **initials** (not check marks) to indicate that the items below were addressed]:

The nature of the assessment and treatment, including the clinical reason(s) for the assessment and treatment of the above area(s) and the draping methods to be used

The expected benefits of the assessment and treatment

The potential risks of the assessment and treatment

The potential side effects of the assessment and treatment

Alternative courses of action

Likely consequence of not having the treatment

That consent is voluntary

That I can withdraw or alter my consent at any time

All above reviewed

I voluntarily give my informed consent for the assessment and treatment as discussed and outlined above.

Client Name (print): _____

Client Signature: _____

Date: _____

RMT Signature: _____



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MEDICAL RECORDS RELEASE FORM

I, _____, hereby authorize the release of my medical/ massage therapy record or copies of the same to such parties that the therapist may deem necessary as it relates to my case, and do hereby hold harmless anyone for such actions.

Patient Signature: _____

Witness: _____

Date: _____

REGISTERED MASSAGE THERAPY FEE POLICY

The fees for massage therapy treatments are:

Length of Treatment	Adult Fees	HST	Total Fee (+HST)	Student/Senior Fees	HST	Total Fee (+HST)
30 minutes	\$54.87	\$7.13	\$62.00	\$47.79	\$6.21	\$54.00
45 minutes	\$67.26	\$8.74	\$76.00	\$60.18	\$7.82	\$68.00
60 minutes	\$79.65	\$10.35	\$90.00	\$70.80	\$9.20	\$80.00
90 minutes	\$104.43	\$13.58	\$118.00	\$97.35	\$12.65	\$110.00

***Hot Stone Massage with Fazena and Kelly**

Length of Treatment	Fee	HST	Total Fee (+HST)
60 minutes	\$106.20	\$13.81	\$120.00

*I am aware that I am responsible for payment by Cash, Debit, Visa, MasterCard, or Cheque (\$25 charge will be applied for NSF cheques)

*I understand that there is a fee of \$25 if I miss or cancel my appointment with less than 24 hours notice.

*I understand that from Dec 14–Dec 31, and all **Saturday appointments**, if I miss or cancel my appointment less than 24 hours ahead of time the fee will be equal to the fee for massage for that time. Example: one hour massage missed fee is \$90. Credit card number or pre pay will be expected during Dec 14–Dec 31.

I also understand that if I am late for my appointment, my treatment will be reduced accordingly.

Patient Signature: _____ Date: _____