

Holy Meadows Chiropractic

420 Essa Rd. Unit 3C
 Barrie, ON
 L4N 9J7

Tel/FAX: (705) 728-9999

Massage Therapy Rates Of Service:

1.5 hour massage- \$115.00, 1 hour massage- \$80.00,
 45 minute massage- \$65.00, 30 minute massage- \$45.00 **Date:** _____

Name: _____ Age: _____
 Address: _____ Home Phone#: (___) _____
 City: _____ Province: _____ Postal Code: _____
 Date of Birth: _____ E-Mail Address: _____

 Occupation: _____
 Employer: _____ Work Phone #: (___) _____
 How did you hear about our clinic? _____

Health History: Please indicate conditions you are experiencing, or have experienced:

<p>Respiratory: ___ chronic cough ___ shortness of breath ___ bronchitis ___ asthma ___ emphysema ___ family history of the above?</p> <p>Cardiovascular: ___ high blood pressure ___ low blood pressure ___ CHF ___ heart attack ___ phlebitis ___ stroke/ CVA ___ pacemaker or similar device ___ heart disease</p> <p>Skin: ___ skin conditions/sensitivities List: _____</p> <p>Women ___ Pregnant? Due Date _____</p>	<p>Other Conditions: ___ loss of sensation ___ diabetes? Type & onset: _____ ___ arthritis ___ family history of arthritis ___ epilepsy ___ cancer ___ allergies? List: _____ ___ fibromyalgia</p> <p>Head/ Sensory: ___ vision problems ___ vision loss ___ ear problems ___ hearing loss ___ headaches or ___ migraine</p> <p>Infections: ___ hepatitis ___ skin ___ TB ___ HIV ___ Other: _____</p>	<p>Soft tissue/ joint discomfort & its nature (ie: ache/ pains/ sprain): ___ head/neck _____ ___ shoulders/arms _____ ___ upper back _____ ___ middle back _____ ___ low back _____ ___ hips/legs _____ ___ knees _____ ___ feet/ ankle _____ ___ other _____ ___ car accidents? when? _____</p> <p>Other Medical Conditions (eg: digestive concerns, gynecological conditions, hemophilia, etc.) _____</p> <p>Of Special Note: (artificial joints, internal pins, wires, special equipment): _____</p> <p>Are you receiving any other treatment? (ie: chiropractic, naturopath?) ___yes, ___no, Please specify _____</p>
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Current Medication(s) _____ Condition it treats _____
 Surgeries _____ Injuries _____
 Family Physician _____ Address _____

CONSENT TO TREATMENT

I hereby request and consent to the performance of therapeutic massage treatment, and other indicated modes of treatment including hydrotherapy, remedial exercise therapy, and home care instruction by the Registered Massage Therapist named below.

I have had the opportunity to discuss with the R.M.T. named below, the nature and purpose of these therapeutic treatments, their intended benefits and possible adverse effects. I understand treatment and draping procedure, and have been informed adequately regarding fee schedule and method of payment.

I understand that at any point in time, I may:

- *choose not to receive treatment on any given day
- *discuss any potential modifications or alternatives
- *discontinue or terminate treatment altogether

I have read the above consent. I have also had the opportunity to ask questions about its content, and by signing below, I agree to the above mentioned massage treatment.

_____ Hereby consent to the therapeutic massage treatment by
Print Patient Name

_____ Registered Massage Therapist
Print R.M.T. Name

Signature of Patient

Date