sydneystarkormt

massage intake/life story

Name: _____
(last) (first) (initial)

Sex: □**M** □**F** □**N** DOB: (dd/mm/yy) ____/____/_____ Height:_____ Weight:_____

Home address: _____
(street) (city/province) (postal code)

Phone number: _____(_____)_____(_____)_____(_____)_____
Home Work Cell

E-mail address: _____
*Your email will be used to send appointment reminders and receipts for your treatments.

Do you consent to receiving the occasional email ? □yes □no

Occupation: _____

Where did you hear about us? _____

In case of emergency, who should we notify/phone: _____

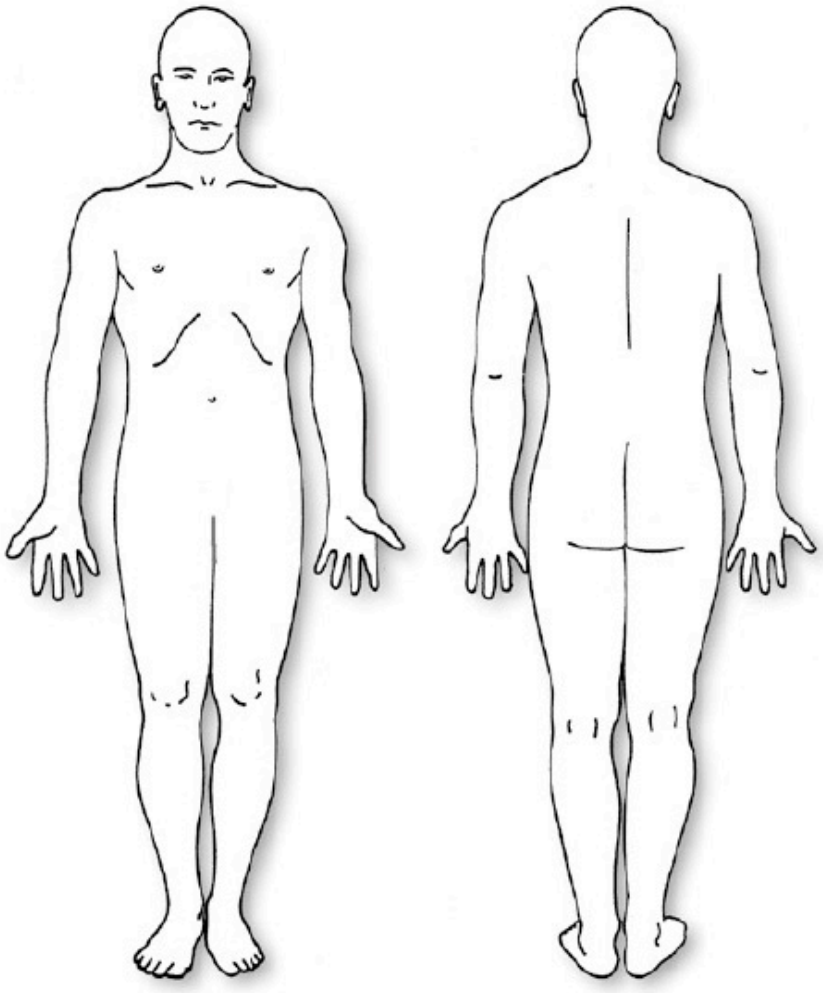
Relationship to you:_____Phone number:_____

Is this a Motor Vehicle Accident case? □yes □no (If so, please let us know.)

Are you **pregnant**, or is there a possibility of pregnancy: □yes □no

Signature: _____ Date: _____

Pain Diagram



Please indicate the areas where you are feeling pain or discomfort, according to the following scale.

Sensation:	Indicate using a:
Sharp pain	S
Numbness/Tingling	N
Achy/Dull pain	A
Burning pain	B
Decreased sensation	↓
Increased sensation	↑
Other, please specify:	?

General Systems Review

Please select any items that relate to your condition or body.

Respiratory
- □ Allergies
- □ Asthma
- □ Bronchitis
- □ Chest pain
- □ Cough
- □ Emphysema
- □ Frequent Colds
- □ Hay fever
- □ Pneumonia
- □ Smoker
- □ Tuberculosis

Hair
- □ Colour changes
- □ Recent loss

Ears
- □ Buzzing
- □ Discharges
- □ Infection
- □ Ringing
- □ Dizzy

Vascular
- □ Anemia
- □ Discoloration
- □ Easy bleeding
- □ Easy bruising
- □ Hemorrhoids
- □ Cold hands/feet
- □ Leg pain after walking
- □ Raynaud's
- □ Swelling
- □ Thrombophlebitis
- □ Tranfusions
- □ Varicose veins

Endocrine
- □ Diabetes
- □ Hyperthyroid
- □ Hypothyroid
- □ Increased thirst
- □ Water retention
- □ Cold intolerance
- □ Heat intolerance
- □ Increased sweating

Skin
- □ Acne
- □ Boils
- □ Colour changes
- □ Dermatitis
- □ Eczema
- □ Fungal infection
- □ Dryness
- □ Goiter
- □ Herpetic infection
- □ Itching
- □ Lumps
- □ Pain
- □ Polyps
- □ Psoriasis
- □ Rashes
- □ Scars
- □ Shingles
- □ Skin Tags
- □ Steroid therapy
- □ Swelling

Musculoskeletal
- □ Arthritis
- □ Fractures
- □ Gout
- □ Hernia
- □ Back pain
- □ Neck pain
- □ Shoulder pain
- □ Elbow pain
- □ Wrist pain
- □ Hand pain
- □ Hip pain
- □ Knee pain
- □ Ankle pain
- □ Foot pain
- □ Muscle injury
- □ Stiffness
- □ Osteoarthritis
- □ Rheumatoid arthritis
- □ Tenderness
- □ Fibromyalgia
- □ Chronic fatigue
- □ Osteoporosis

Vision
- □ Redness
- □ Glaucoma
- □ Light Sensitivity
- □ Blurred vision
- □ Cataracts
- □ Double vision
- □ Dyslexia
- □ Tearing

Head
- □ Concussion
- □ Headaches
- □ Migraines
- □ Insomnia
- □ Difficulty with memory
- □ Difficulty concentrating
- □ Mental illness
  Specify:

Neurological
- □ Alzheimer's
- □ Burning
- □ Epilepsy
- □ Fainting
- □ Numbness
- □ Parkinson's
- □ Seizures
- □ Tingling
- □ Tremors
- □ Multiple sclerosis
- □ Other:

Numbness or Tingling
- □ Shoulders
- □ Arms
- □ Hands
- □ Hips
- □ Groin

Cardiovascular
- □ Angina
- □ Ankle swelling
- □ Arrhythmias
- □ Arteriosclerosis
- □ Blood clots
- □ Chest pain
- □ Cold/blue hands, feet
- □ Low blood pressure
- □ Heart racing
- □ Shortness of breath
- □ Pounding sensation
- □ Heart attack
- □ Heart murmur
- □ Chronic heart failure

Family History
- □ Arthritis
- □ Genetic condition
  Specify:
- □ Auto-immune condition
  Specify:
- □ Cancer
- □ High blood pressure
- □ Diabetes
- □ High cholesterol
- □ Thyroid problems
- □ Heart disease
- □ Stroke
- □ Vascular condition
  Specify:

Other:
- □ Cancer
- □ Chemotherapy

Informed Consent to Massage Therapy and Cupping

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

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

I acknowledge that the 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 therapist must be fully aware of my existing medical conditions. I have completed my medical history form as provided by my therapist and disclosed to the 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 therapist to release or obtain information pertaining to my condition(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 to treatment and intend this consent to cover the treatment discussed with me and such additional treatment as proposed by my therapist from time to time, to deal with my physical condition and for which I have sought treatment. I understand that at any time I may withdraw my consent and treatment will be stopped.

Bruising, redness, tenderness, and inflammation are normal side effects from any deep tissue work and you should expect to feel any of these for a few days following your treatment.

Cupping is the inverse of massage. Rather than applying pressure to muscles, the suction uses pressure to pull skin, tissue and muscles upward. I often combine cupping with massage into one treatment, but it could also be used alone. Cupping involves placing glass, or plastic jars on the skin and creating a vacuum by suctioning out the air. The underlying tissue is raised, or sucked, partway into the cup. The purpose of cupping is to enhance circulation, help relieve pain, remove "heat" and pull out the toxins that linger in your body's tissues.

You usually will feel a tight sensation in the area of the cup. Often, this sensation is relaxing and soothing. Depending on your comfort and your practitioner's assessment of the problem, cups may be moved around or left in place. They may remain on your body briefly or for longer amounts of time. Each treatment is unique to you on that particular day. Cupping is fairly safe, but you may experience mild bruise like tenderness lasting a few days following your treatment. In rare cases faint markings may remain for several weeks, it is important to inform your therapist if this occurs.

Questions or Concerns
You are encouraged to ask questions at any time regarding your assessment and treatment. Bring any concerns you have to your practitioner's attention. If you are not comfortable, you may stop treatment at any time.

Dated this ___ day of _____, 20_____.

Name: _____ _____

(please print) Patient Signature (or Legal Guardian)

sydneystarkormt : stuff you should know

60 minutes	$100.00
90 minutes	$135.00

Payment is due when services are rendered. Exceptions include only Motor Vehicle Accidents, which will be billed directly to your insurer provided that you have given the necessary information to do so. If this is a motor vehicle accident case, every effort will be made to obtain payment from the insurance company, but in the event that the insurance company denies payment, the patient is responsible for the cost of any treatments to date.

Twenty four (24) hours notice is required for cancellation of appointments, or a penalty charge of the full price of your appointment will apply. Extenuating circumstances/emergencies will be given special consideration.

Patients with extended health benefits must **submit payment up-front**, and then submit their receipts to their insurance company for reimbursement. The patient is responsible to check with their insurance company to determine if their treatment will be covered.

If this is a WCB (Worker's Compensation Board) case, please note that *sydneystarkormt* is not a WCB authorized provider. If you still wish to obtain treatment, you will be responsible for the cost of treatment, and you will be provided with a receipt. *sydneystarkormt* is not responsible if the fees are not reimbursed by WCB.