Carissa Barke, RMT
Therapeutic & Relaxation Massage

Name: _____ Date: _____

Address: _____ Province: _____

City: _____ Postal Code: _____

Phone: _____ Date of Birth: _____

Email: _____

Do you wish to receive email newsletters and be kept up to date with promotions? ☐ Yes ☐ No

Occupation: _____

In case of emergency, contact: _____ # _____

How did you hear about us? _____

What are your goals for today's massage? _____

HEALTH HISTORY

Have you experienced massage before? ☐ Yes ☐ No Date of last massage: _____

Are you currently being treated by a chiropractor or physical therapist? _____

Past injuries/accidents & dates: _____

Past surgeries & dates: _____

Do you have any known allergic reactions? _____

Medications/Supplements (including pain relief): _____

PLEASE INDICATE CURRENT CONDITIONS WITH A 'C' AND PREVIOUS WITH A 'P':

Respiratory:
___ Chronic Cough
___ Shortness of Breath
___ Bronchitis/Asthmas
___ Sinus Infections
___ Emphysema
___ Tuberculosis
___ Other: _____

Skin:
___ Rashes
___ Cuts/Open sores
___ Warts
___ Athlete's Foot
___ Contagious skin disease
___ Bruise easily
___ Sensitivities/allergies

Infections:
___ Hepatitis
___ HIV

Women:
___ Pregnant (due: _____)
___ Painful menstruation
___ Hysterectomy
___ C-section

Cardiovascular:
___ Cold hands/feet
___ High blood pressure
___ Low blood pressure
___ CCHF or Heart Attack
___ Varicose Veins or phlebitis
___ Stroke/CVA
___ Pacemaker or other devices
___ Swelling in hands/feet
___ Deep vein thrombosis

Digestive:
___ Constipation
___ Nausea/vomiting
___ Ulcers/blood in stool
___ Liver/kidney problems
___ Quick weight loss/gain
___ Appetite changes
___ Colitis/Crohn's/IBS

Head and Neck:
___ Tension headaches
___ Migraines
___ Tinnitus (ringing in ears)
___ Tooth/jaw/ear pain
___ Vision problems/loss
___ Hearing loss
___ Dizziness/lightheaded
___ Other: _____

Other Conditions:
___ Diabetes (type: _____)
___ Epilepsy
___ Insomnia
___ Depression/Anxiety
___ Multiple Sclerosis
___ Cancer (type: _____)
___ High Sensitivity/SPS
___ Other: _____

Soft Tissue/Joint/Nerve:
___ Fibromyalgia
___ Arthritis/Osteoarthritis
___ Rheumatoid Arthritis
___ Osteoporosis
___ Fracture (where: _____)
___ Thoracic Outlet Syndrome
___ Head trauma/concussion
___ Whiplash/car accident
___ Neck pain/stiffness/injury
___ Arm pain/weakness/tingling
___ Back pain/stiffness/injury
___ Leg pain/weakness/injury
___ Knee or foot pain/injury
___ Tendonitis/Tenosynovitis
___ Bursitis or dislocations
___ Sport/work-related injury
___ Carpal tunnel syndrome
___ Loss of sensation

Additional Information: _____

_____

CURRENT CONDITION

Describe your current condition: _____

_____

How long have you had this condition? _____

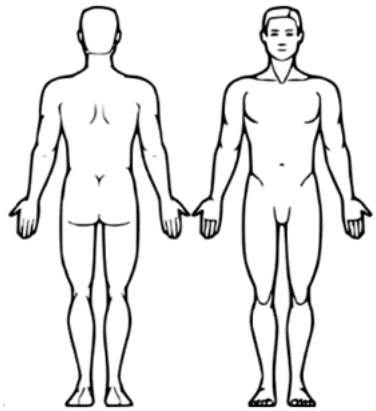
How did it start? _____

What aggravates it? _____

What relieves it? _____

Using the diagram on the right, indicate any area you're experiencing discomfort.

On a scale of 1-10, rate your disccomfort (1=less, 10=more) _____



I hereby agree that the information above is accurate and completed to the best of my knowledge:

Client Signature: _____ Date: _____

Carissa Barke, RMT
Therapeutic & Relaxation Massage

Client Consent

I understand that:

The relationship between the client and the therapist is a confidential one and that all information provided to the therapist is to be kept confidential.

A confidential record will be kept of the health services provided to me. It will not be released to others without my consent, unless required by law.

The information given is accurate, and I agree to update the therapist of health changes at future appointments as appropriate.

The risks of treatment may include, but are not limited to: dizziness, bruising, headache, thirst, aggravation of symptoms, and/or minor discomfort and soreness following treatment.

Treatment may induce complications in people with certain conditions, such as cardiovascular disease, diabetes, osteoporosis, or stroke. It is therefore important to inform the therapist of all conditions or medications.

It may be necessary to obtain permission from my healthcare provider to receive or continue therapy.

My body will be properly draped at all times for comfort, security, and warmth.

The massage is solely for the purpose of therapeutic massage and the therapist also has the right to be free from any unwanted, harmful, offensive, and/or physical contact or behaviour.

I will inform the therapist of any discomfort so that the application of pressure or strokes may be adjusted to me level of comfort.

I have the right to request and require that any procedure or technique be modified, changed, stopped, or simply not performed.

I accept full responsibility for the fees incurred during care and treatment.

Late cancelled or no-show appointments may be subject to a fee of $25.

The massage is ancillary treatment and can be incorporated with complimentary medical treatment.

Written Consent

I have read, understand, and agree to the information provided for the Client Consent and will proceed with receiving massage from the therapist.

Signature: _____ Date: _____

Full Name: _____