MuscleElements
Health & Wellness

#3, 9 Chippewa Road, Sherwood Park, AB, T8A 6J7
Phone: 780.410.1100 Fax: 780.410.1186

Today's date:

Massage Therapy Information Form

Last Name:	First Name:	Circle: Mr. Ms. Mrs. Dr.

Birth date: DD - MM - YYYY	Age:	Circle # of preferred contact:

Address:		Phone (home):
City:	Province:	Phone (work):
Postal Code:	Email:	Phone (cell):
Are you happy to be contacted by email?: ☐yes ☐no		Occupation:

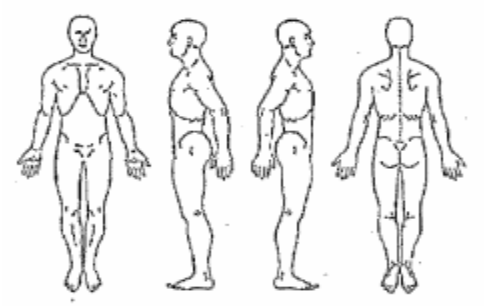
Reason for Visit:

Have you seen a registered massage therapist before?

Please indicate if any of the conditions below apply:

	Heart conditions		Stroke		High Blood Pressure		Low Blood Pressure
	Respiratory Condition		Deep Vein Thrombosis		Neurological Condition		Spinal or head injury
	Diabetes		Kidney Disorder		Cancer		Hepatitis
	HIV/AIDS		Sprain/Strain/Fracture		Osteoporosis		Vomiting
	Jaw Pain		Dizziness		Fainting		Contagious Illness
	Skin Condition		Digestive Problems		Haemophiliac		Pacemaker
	Lung Condition		Epilepsy		(Possibility of) Pregnancy		Upcoming Surgeries
	Loss of sleep		Numbness		Tingling		Headache
	Migraine		Nervousness		Swollen ankles		Varicose Veins
	Poor Circulation		Osteoarthritis		Rheumatoid Arthritis		Sciatica
	Herpes		Athlete's Foot		Warts		Poor Appetite
	Belching/Gas		Constipation		Nausea		

On the figures below, please indicate the areas of concern/pain:



Sensations/pain characteristics (check all that apply):
Sharp ___ Burning ___ Moving ___ Tingling ___
Dull ___ Severe ___ Stabbing ___ Shooting ___ Throbbing ___
Numbness ___

What relieves the pain (ice, rest, activity, massage, heat)?
_____

What aggravates the pain (weather, heat, cold, rest, activity)?
_____

Please indicate any Joint/Soft Tissue Pain:	
Hands	Hips
Feet	Shoulders
Arms	Neck
Legs	Knees
Other	

Please list any allergies (food, drugs, environmental, etc):	
1.	2.
3.	4.

Please indicate major illnesses, injuries and surgeries in the past:

Please list any medications and/or supplements you are taking:

Do you participate in the following physical activities? If so, please indicate how often (daily, weekly, monthly)			
Yoga:	Running:	Fitness Class:	Gym:
Biking:	Swimming:	Walking:	Other:

On a scale of 1-10, how would you rate your daily energy level (10 being best)?

What is your occupation/duties?

If you were asked to describe yourself from an emotional standpoint, what would you say (i.e. irritable, worrier, anxious, sad, impatient, stressed, etc.)

How many glasses of water do you drink in a day?

Please indicate how you heard about us: (circle all that apply)

Internet Search Social Media Local Business Direct Mail Friend/Colleague Gift Certificate
Other:_____

Privacy Policy

The information received and collected about our clients/patients from their visit to Muscle Elements is strictly private and confidential. It is used and viewed only by the healthcare professionals and staff employed by Muscle Elements, unless, in the best interest of the client/patient, a practitioner determines that there is a need to communicate with another person or healthcare professional outside of Muscle Elements (also, Muscle Elements will not give, share, sell, or transfer any personal information to a third party unless required by law). Under absolutely no circumstances would this communication happen without the signed consent of the client/patient. The client/patient information will be stored both in digital and hard copy format on Muscle Elements premises.

_____ _____
Print name in full (Print name of representative if represented by another)

_____ _____
Signature (Signature of Representative)

_____
Date

Appointment Policy

Thank you for choosing Muscle Elements. We have a 24 hour cancellation policy. If you are unable to provide this notice, we will charge you in full for the missed appointment **if we are unable to fill the spot**. We often have a waiting list and if given enough notice, we can fill the appointment. If you have an emergency, please let us know so that we can treat your specific situation with personal attention. **We do not consider work conflicts as emergencies**. This cancellation policy is necessary for our small business to continue to serve our clients in need of treatment, and also to make our services a feasible career for our practitioners. The practitioners practice a maximum of 4-5 hours per day so that you can be sure to get high quality treatment and so that they can stay healthy and injury free. One missed appointment out of 5 appointments has a significant financial impact. It is possible to cancel appointments through our online booking system up to 24 hours before the appointment. If you need to cancel within 24 hours of your appointment time please call or email the clinic.

Any questions regarding my appointments have been addressed.
I have read this statement and fully understand and agree to it.

_____ _____

Print name in full

(Print name of representative if represented by another)

_____

Signature

_____

(Signature of Representative)

_____

Date

Informed Consent

I hereby request and consent to receive Massage Therapy from a Registered Massage Therapist in this clinic. I agree to communicate with my massage therapist in order to build a treatment plan that will suit me. I understand that Massage Therapy is intended to enhance relaxation, reduce pain caused by muscle tension, increase range of motion, improve circulation, improve body awareness, increase sense of well-being, and offer a positive experience of touch.

The general benefits of massage, possible massage contraindications and the treatment prodedure have been explained to me. I understand that Massage Therapy is not a substitute for medical treatment or medications, and that it is recommended that I concurrently work with my primary health care provider for any condition I may have. I am aware that the massage therapist does not diagnose illness or disease, does not prescribe medications, and that spinal manipulations are not part of Massage Therapy. I have informed the massage therapist of all my known physical conditions, medical conditions and medications, and I will keep the massage therapist updated on any changes.

_____

Print name in full

(Print name of representative if represented by another)

_____

Signature

_____

(Signature of Representative)

_____

Date

If you have benefits for Massage Therapy that you would like us to try to direct bill for please let the receptionist know before your treatment when possible.

Thank you!