Saanich massage therapy & wellness

University Heights Shopping Centre
404-3980 Shelbourne Street
Victoria, BC, V8N 6J1
Phone / Fax 250-385-3880
info@saanichmassage.ca
www.saanichmassage.ca

Confidential
Patient History & Consent Form

Name ______________________

Address ______________________

____

Postal Code ______________________

Phone (home) ______________________

(cell) ______________________

(work) ______________________

Email ______________________

Occupation ______________________

Birthdate ______________________ (month / day / year)

Gender ______________________

Family Doctor ______________________

Phone ______________________

Referring Professional ______________________

Phone ______________________

Is this an ICBC or WCB related treatment? No / Yes

Extended Medical Insurer ______________________

How did you hear about our Clinic or RMT? ______________________

Please indicate if you believe any of the following apply to you: Circle C (Current) or P (Past)

Heart Attack	C P	Headaches / Migraines	C P	Joint Dislocation	C P	Anxiety	C P
High / Low Blood pressure	C P	Dizziness / Fainting	C P	Bone Fracture	C P	Depression	C P
Stroke or Aneurysm	C P	Nausea	C P	Arthritis	C P	Asthma	C P
Pace Maker	C P	Spinal Injury	C P	Osteoporosis	C P	Diabetes	C P
Other Heart condition	C P	Head Injury	C P	Rods / Pins / Shunts	C P	Hepatitis	C P
Varicose Veins	C P	Epilepsy / other seizures	C P	Implants ____________	C P	HIV	C P
Bruise Easily	C P	Other Neurological Condition	C P	Transplant ____________	C P	Cancer	C P
Kidney Disease	C P	Corrective Lenses / Contacts	C P	Skin Condition	C P	____________	
Other Urinary condition	C P	Chronic Sinusitis	C P	Irritable Bowel / Colitis	C P		
Other respiratory condition	C P	Other condition not listed ____________					

Please list any Medications you presently take: ______________________

Known Allergies (including medications, food, seasonal, oils etc.): ______________________

Do you have a family history of medical conditions? ______________________

____

Have you ever been hospitalized, had any major accidents, illnesses or surgeries? If yes please elaborate: ______________________

____

____

Please describe your current condition & symptoms. Use the diagram to the right to indicate affected areas. ______________________

____

____

____

How long have you had this condition? ______________________

How did it start: ______________________

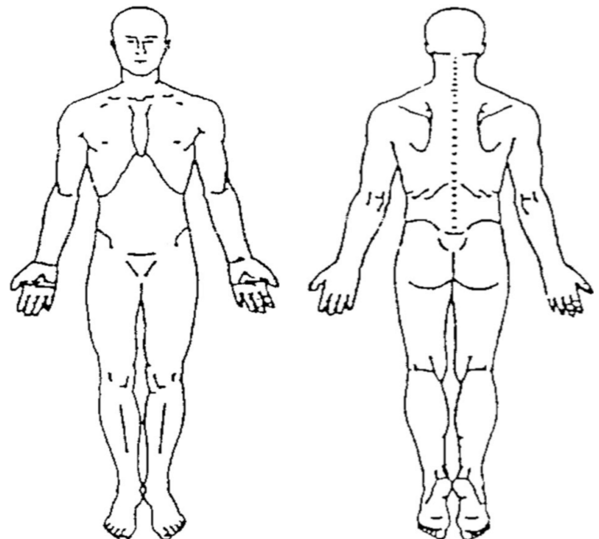
____

____

Use the following symbols to indicate the nature of your symptoms on the diagram:

O Aching   X Stabbing   # Burning

→ Shooting   /\/\/ Numbness/Tingling



Please read this document carefully and completely
Ask your RMT any questions you may have about this form or its contents.
Ask questions about your treatment at ANYTIME.
IMMEDIATELY advise your RMT if you become uncomfortable in any way with your treatment.

Treatment Plan: My initials confirm that:
___ I UNDERSTAND that my RMT will discuss the following elements of the Treatment Plan with me:

- My goals for my treatment
- The nature and purpose of the proposed treatments and how they will address my goals
- The possible alternative methods of treatment
- The risks involved, including the possible complications and side effects, examples of which can include: bruising, aching, discomfort, short term aggravation of symptoms, skin irritation
- The areas of my body that will be touched during treatment and why
- My options for disrobing prior to the treatment
- My options for draping during the treatment

Concerns Addressed: My initials confirm that:
___ I understand that I may address concerns with the treatment plan
___ I understand my RMT will address my concerns to my satisfaction before the treatment has begun
___ I agree to alert my RMT immediately if I develop a concern at any time

Consent to Treatment: My initials confirm that:
___ I authorize and consent to the RMT performing the treatments described to me in the Treatment Plan
___ I acknowledge that I may withdraw my consent to this treatment at anytime
___ I agree to tell my RMT if my goals of treatment change, as they may need to amend the Treatment Plan
___ I agree to tell my RMT immediately if I withdraw my consent

Disclosure of Medical History: My initials indicate that I acknowledge and understand that:
___ It is important for the RMT to know my relevant medical history
___ I will disclose any new such condition that may develop after my completion of this form
___ The information disclosed by me is true and complete to the best of my knowledge

Confidentiality: The contents of this form and my patient records will be kept confidential unless I have expressly or impliedly consented to the release of my information or where there is a legal requirement to provide my information to a third party.

___ **Sharing of My Patient Record:** My initials confirm that I request and authorize my RMT to provide to the Clinic and to other health care practitioners who provide me with treatment, copies of any patient record created by my RMT. I understand this will enable the Clinic to maintain a complete patient record on my behalf. I understand that I may revoke this permission in writing at any time in the future.

No Guarantee of Results: My initials confirm that:
___ I acknowledge that no guarantee or assurance of results can be made to me regarding my treatments

Please Note: Your appointment time has been reserved for you. In courtesy of your therapist and fellow patients, we ask you provide us with 24 hours notice of cancellation. Late cancelations or no shows will be billed the full amount of the treatment. Payment for all treatment, whether private or insured, is ultimately the responsibility of the patient.

___ My initials confirm that I authorize the clinic and its associated RMTs to collect my personal and medical information as documented above in order to contact me, and give permission for the clinic to leave messages regarding appointments at any of the contact numbers I have provided above.

Signature of Patient*: ______________________________ Today: (mm/dd/yyyy): ________________

(* In the case of a person incapable of providing consent, signature of Parent or Guardian, in which case the Name & Relationship of Person Signing: ____________________________