JADE WELLNESS CLINIC
3050 Yonge Street, Suite 201
Toronto ON M4N 2K4 416-489-3377

REGISTERED MASSAGE THERAPY INTAKE FORM

Name _____ Date: _____ Update 1:_____ 2: _____

Date of Birth (dd)_____(mm)_____(yy)_____ Occupation_____

Home Phone (_____)_____Cell (_____)_____Business (_____) _____

Address_____
Street City Province Postal Code

Email_____Communicate by email Y / N

Emergency Contact_____Phone (_____) _____

Please tell us who referred you! _____

CURRENT HEALTH CONDITION(S) *Indicate conditions you are currently experiencing or have previously experienced*

Please describe your general health status: _____
Primary complaint today: _____
Health professional seen for this condition: Y / N Specify: _____
Have you previously received massage therapy care? Y / N

Head/Neck
Headaches
Type _____
Vision problems
Earaches

Respiratory
Do you smoke Y / N
Shortness of breath
Asthma
Breathing problems
Chronic cough

Cardiovascular
High blood pressure
Low blood pressure
Congestive heart failure
Poor circulation
Heart disease
Phlebitis/varicose veins
Stroke

Infections
Herpes
Hepatitis
Plantar warts
TB
HIV/AIDS
Other_____

Other Medical Conditions to Note
(pins, wires, artificial limbs, etc.)

Skin
Skin conditions
Type(s) _____
Do you bruise easily Y / N

Other Conditions
Cancer
Diabetes
Seizure Disorder
Loss of Sensation(where)_____
Difficult digestion
Constipation
Liver Failure
Gallstones
Kidney stones
Fibromyalgia
Sinus Infections
Lupus
Allergies
Insomnia

Arthritis
Dr. diagnosed Y / N
Affected areas _____
Family history _____

GYN
Pregnant Y / N
Due Date _____
Menstrual issues or pain Y
Gynecological conditions Y
Type _____

Medical Doctor
Name _____
Phone _____
Address_____
Last visit

Current Medications/Prescriptions
Name Indication
_____/_____
_____/_____
_____/_____

Other Muscle Pain & Stiffness (circle)

Neck	Shoulder L/R
Low back	Leg L/R
Mid back	Knee L/R
Upper back	Ankle L/R
Shoulder L/R	Feet L/R

Other _____

Surgery
Type(s) _____
Dates _____
Current pain _____

Injury
Type(s) _____
Dates _____
Current pain _____

Signature: _____

JADE WELLNESS CLINIC
3050 Yonge Street, Suite 201
Toronto ON M4N 2K4 416-489-3377

INFORMED CONSENT ***for Massage Therapy Assessment and Treatment***

I have been informed about the proposed physical assessment and the nature of the massage therapy treatment. I have been informed of and understand the benefits, risks, side effects, contraindications (if present), alternative courses of treatment and consequences of not having the treatment. I understand that results are not guaranteed.

I am fully aware of the cost and duration of my treatment. The therapist will give instruction on dressing/undressing procedures, as well as instruction on positioning and covering during the treatment. **I understand that it is my right to stop or modify the treatment at any time and that the massage therapist expects my input regarding the comfort of pressure throughout the treatment.** I understand that my treatment may change from time to time, and the necessary functional abilities test may be performed at the therapist's professional discretion.

All information in my file will be kept confidential, although my file may be shared among therapists in this facility in order to ensure the flow of accurate information and the quality of care. I understand that written authorization will be obtained prior to any release of information, except when required by a court of law.

I have read the above consent, and had the opportunity to ask questions. I agree to the proposed massage therapy protocol presented by the registered massage therapist. I intend this consent to cover the entire course of treatment for my present condition and any future condition(s) for which I seek treatment.

Registered Massage Therapy Rates (+HST)

30 min	40 -
45 min	60 -
60 min	80 -
75 min	100 -
90 min	120 -
120 min	150 -

_____ _____
Signature Date

CANCELLATION POLICY

24 hours of notice must be given by phone (not email) to cancel all appointments. Failure to do so will result in a charge of **25%** of the cost of the scheduled treatment, to be paid prior to your next treatment. It is the responsibility of the client to remember scheduled appointments; however, we are happy to provide a reminder call the day before your appointment if you request it.

_____ _____
Signature Date

INFORMED CONSENT ***for the Treatment of Sensitive Areas***

The College of Massage Therapists of Ontario requires written consent for the treatment of sensitive areas. Consent must be given prior to treatment, and **can be withdrawn at any time**. Please check consented areas:

Gluteals (buttocks)	€
Abdomen	€
Medial (inner) thigh	€
Breast	€
Intraoral (inner jaw, for TMJ)	€

_____ _____
Signature Date