Massage/Shiatsu Therapy Form

Please complete this form as thoroughly as possible. The information provided is kept confidential according to The Pacific Wellness Institute Privacy Policy. This completed form is required before your session.

Date:______________________________ Height:________________ Weight:_____________

Mr. Mrs. Ms. Dr.

Family Name:________________________________ Given Name: _________________________________

Address:

____

____Apt. #___________ Postal Code________________

Telephone: (_______) __________________(H) (_______) ________________________ (B)

E-mail: ____

Date of Birth (mm/dd/yr): ________________ Occupation: ____

How did you hear about us? Please specify: ____

If you are referred, please indicate the name of the person who referred you: ___________________________

Did the person who referred you suggest that you see any particular practitioner at Pacific Wellness?
If so, whom? ______________________

Are you claiming all__ or part __of our fee under insurance? ☐ Yes ☐ No

Does your insurance company allow direct billing from us? ☐ Yes ☐ No ☐ Don't know

If you are involved in an unsettled car accident case please indicate here_____________________________

Name of your Family Physician: _________________________ When was your last check up? ___________

Results? ____

Have you ever received a professional massage or shiatsu before? No_______ Yes_______

If so, Name of previous therapist:____

When was your last visit?__________ Briefly describe your experience: ______________________________

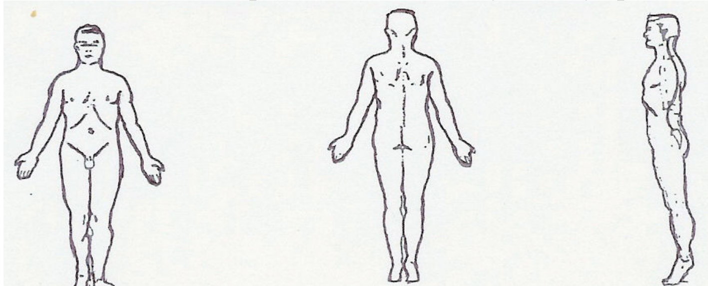
Is the purpose of your visit:
- ☐ to relieve stress and tension?
- ☐ to address specific health concerns? (please specify):____

If any other health practitioners are involved in the care of the condition(s) you indicated, please list their names and specialties:

____

Are you pregnant? No________ Yes_______ If so, how many months? ___________________________

Please mark the areas of pain, discomfort or any other symptoms on the pictures below:



x Severe Pain
≡ Moderate Pain
\\ Stiffness/Tension
~ Numbness/Tingling
I Skin infection/irritation
P Internal pins/wires
S Scars (surgery/ injury wounds)

Are you suffering from any mental/ psychological disorders? ____

List all surgery, accidents, and falls:

Date	Details

Please check below, if you have any of the following conditions. Include details (if any):

□ Heart problems	□ High blood pressure	□ Diabetes	□ Constipation
□ Respiratory problems	□ Low blood pressure	□ Osteoporosis	□ Diarrhea
□ Spinal/joint disorder	□ Anemia	□ Palpitations	□ Tumor/Cancer
□ Circulation problems	□ Dizziness	□ Menstrual problems	□ Allergies
□ Blood clots	□ Fainting	□ Skin problems	□ Infectious disease
□ Varicose veins	□ Epilepsy	□ Sleep apnea	□ Seizures
□ High cholesterol	□ Low blood sugar	□ Hormonal disorder	□ Bruise easily
□ Vision/Hearing loss	□ Decreased sensation	□ Headaches	□ Internal pins/wires

Details:____

Please indicate if you have any other health conditions that were not already mentioned.

____

How long ago did you eat your last meal? ______________________

If you are taking any medication, vitamins, herbs, or nutritional supplements please list below:

Drug/Supplement Name	Dosage	For What Condition?	For How Long?
1.______________________	______________	__________________________	___________________
2.______________________	______________	__________________________	___________________

If you have any life threatening allergies (e.g., anaphylaxis, medication), please list here:

____

In case of emergency call:

Name: ____ Relationship: _____________________________

Phone: ____

Massage Therapy Informed Consent Form

* For clarity, unless specifically indicated, the word 'massage' used on this form includes all types of body work therapy provided at The Pacific Wellness Institute which includes Swedish massage, shiatsu, and reflexology.

Why Massage?

Your massage appointment not only involves actual massage, but also, a consultation, assessment, discussion and home care guidance. Clients come for massage, shiatsu, and reflexology treatment (hereafter 'massage') for a wide variety of reasons. Some receive massage to address their health issues while others use it more for relaxation purposes. The focus of massage and overall composition of the session can be designed differently depending on the main reason for your visit. Your therapist will be happy to best accommodate your preferences, as long as it is deemed safe and appropriate.

In order to deliver the most efficient use of your session time, please answer the following:

- ☐ I have a health condition. Please assess my condition and provide necessary care.
- ☐ I have a health condition, but I want massage today mainly for general muscle stiffness and stress.
- ☐ I am in good health. I want massage today for general muscle stiffness and stress.
- ☐ Other. Please specify: ____

Remedial exercise

In Ontario, massage therapists (RMTs) are trained to provide home care exercises. Please remember that exercise instructions take place during your scheduled massage appointment time and actual hands-on massage time will be reduced accordingly.

- ☐ I am interested in obtaining exercise instructions that may be beneficial.
- ☐ I am not interested in obtaining exercise instructions, but I may be interested in my future sessions.
- ☐ I am not interested in any exercise instructions. Please focus on massage.
- ☐ Other. Please specify: ____

If you have any questions about the procedures used in the massage, please do not hesitate to ask your therapist for an explanation. Please indicate here any additional comments or requests you would like to make:

____

Please read carefully and sign:

I understand that the massage, shiatsu, and reflexology treatment (hereafter 'massage') involves pressure and kneading applied to various parts of the body. If I experience any pain or discomfort during the session, I will immediately inform the therapist so that the pressure and/or strokes may be adjusted to my level of comfort. I understand that massage should not be construed as a substitute for medical examination, diagnosis, or treatment, and that it is recommended that I see a physician for any physical ailment that I may have. I affirm that I have stated all my known medical conditions and answered all questions honestly. I agree to keep the therapist updated as to any changes in my medical profile during the sessions.
I acknowledge that I have read this form and understand the procedures that the practitioner will perform. I consent to receiving massage and intend to apply this consent to all of my future massage sessions at The Pacific Wellness Institute.
I further understand that I may withdraw my consent at any time, in which case I understand that I will not continue to receive treatment.

______________________________________ ___________________________

Signature of Client Date

____

Witness