wholefamily health
6523 – 111 St NW, Edmonton, AB *Phone* 780.756.7736
WHOLEFAMILYHEALTH.CA

Gender Neutral Massage Forms

Date:

Last name / First name / Circle: Miss Ms. Mrs. Dr.

Birth date / Age / Circle # of preferred contact

Address / Phone (home) /

City / Phone (work) /

Province / Postal Code / Phone (cell) /

Email / Occupation /

Height / Weight /

Reason for Visit /

Have you had Acupuncture before? Yes No

Chinese herbal medicine? Yes No

Family Physician name / Family Physician phone /

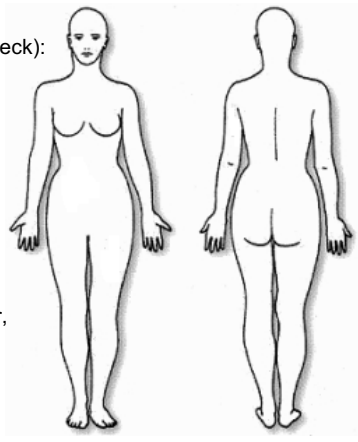
Western Medical diagnosis (if applicable) /

Other medical treatment received (circle) / Physiotherapy Massage Naturopathy Chiropractic Other:

Please indicate with a '**P**' (past) '**C**' (current) '**F**' (family) if any of the conditions below apply:

	Heart conditions		Stroke		High blood pressure		Low blood pressure
	Diabetes		Deep vein thrombosis		Neurological condition		Spinal or head injury
	Respiratory condition		Kidney disorder		Cancer		Hepatitis
	HIV / AIDS		Sprain/strain/fracture		Osteoporosis		Headaches/migraines
	Jaw pain		Arthritis		Dizziness/fainting		Contagious illness
	Skin condition		Digestive problems		Haemophiliac		Wear a pacemaker
	Lung condition		Epilepsy		Possibility of pregnancy		Upcoming surgeries

On the figures below, please circle the areas of concern/pain;



Sensations/pain characteristics (check):
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 list any prescription medication or over the counter drugs currently taking:

1.	2.
3.	4.
5.	6.

Please list herbal medicine and other supplements currently taking:

1.	2.
3.	4.
5.	6.

Please list any allergies (food, drugs, environmental, etc.):

1.	2.
3.	4.

Have you been hospitalized and/or treated for any infectious/serious conditions or surgeries? If yes, briefly explain for what condition or reasons and the year (below).

Do you use the following? If so how often? Cigarettes: _____ Alcohol: _____ Drugs: _____ Coffee: _____ Pop: _____

Do you participate in the following physical activities? If so, please indicate how often:

Yoga:	Running:	Fitness Class:	Gym:
Biking:	Swimming:	Walking:	Other:

How did you hear about Whole Family Health? (Internet, Friend, Doctor, Seminar, Magazine, TV, News, etc.) _____

Please print and email completed forms to info@wholefamilyhealth.ca before your initial appointment. Thank you.

Are you currently pregnant?	Yes		No		If yes, how far along? What is your Estimated Due Date? Are there any high-risk factors? If yes, please explain?
Do you suffer from pain?	Yes		No		If yes, please explain? Is the pain chronic or acute? Quality of pain (stiff/ dull/ stabbing..) What makes it better? What makes it worse? How would you describe the pain? On a scale of 1-10 (10 being the worse)
Have you had any orthopedic injuries?	Yes		No		If yes, please list.
Have you been in a MVA recently?	Yes		No		If yes, please explain. Is there currently an open claim on this MVA injury?
Do you have any sprains, strains or fractures?	Yes		No		If yes, please explain.
Do you have any spasms/ cramps?	Yes		No		If yes, please explain.
Do you have a spinal or head injury?	Yes		No		If yes, please explain.
Do you have limitations of movement?	Yes		No		If yes, please explain.
Do you have paralysis or numbness?	Yes		No		If yes, please explain.
Have you have any upcoming surgeries?	Yes		No		If yes, please explain.
Have you had	Yes		No		What type of massage are you seeking?

a professional massage before?					Relaxation ___Therapeutic/ Deep Tissue ___ Other: What pressure do you prefer? *(Please also verbally communicate discomfort and pressure preference to your therapist.)* Light ___ Medium ___ Deep ___
Are there any areas (face, feet, abdomen, etc.) that you do not want massaged?	Yes		No		If yes, please explain.
What are your goals for this treatment session?					

OPTIONAL QUESTIONS:

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

_____

What is your occupation?

_____

How many hours per week do you work?

_____

What are your duties?

_____

Is your work stressful? Yes___No___ Somewhat___
Do you enjoy your work? Yes___No___Somewhat___

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

Do you have trouble falling asleep? Yes ___No ___Somewhat___

Are you a light sleeper? Yes ___No___ Somewhat___

How many hours per night? _____

Is your sleep disrupted by discomfort/ pain?
Yes ___No___Somewhat___

When you wake do you have difficulty falling back to sleep?
Yes___No___Somewhat___

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Patient Information and Consent Form

Please read this information carefully and ask your practitioner if there is anything that you do not understand.

While massage therapy and other treatments (cupping, reflexology etc..) provided by this clinic have proven to be highly effective in correcting conditions and maintaining overall well-being, practitioners are required to advise clients that there may be some risks. Although practitioners cannot anticipate all the possible risks and complications that may arise with each individual case, you should be aware that the following side effects can occur. If there are particular risks that apply in your case, your practitioner will discuss these with you.

What are the possible side effects of massage?

- Drowsiness, fatigue, dizziness or nausea can occur in some clients, and in some cases, you are advised not to drive;
- Some clients' symptoms may become worse before they improve for 1-2 days following treatment. Please advise your massage therapist if worsening of symptoms continues and/or you are uncertain about how you feel after treatment;
- Bruising (looks like a circular hickey) is a common side effect of cupping;
- Some clients may experience fainting;
- Some clients may also experience emotional release

Statement of Consent

I understand that the massage therapist is providing massage therapy services within their scope of practice as defined by the Massage Therapist Association of Alberta, the Remedial Massage Therapists Association and/ or the Natural Health Practitioners of Canada.

I hereby consent for my therapist to treat me with massage therapy for the above noted purposes including such assessments,examinations and techniques, which may be recommended, by my therapist. I understand that it is my responsibility to clearly communicate discomfort and/or my pressure preferences to the therapist.

I acknowledge that the therapist is not a physician and does not diagnose illness or disease or any other physical or mental disorder. I clearly understand that massage therapy is not a substitute for a medical examination. It is recommended that I attend my personal physician for any ailments that I may be experiencing. I acknowledge that no assurance or guarantee has been provided to me as to the results of the treatment. I acknowledge that with any treatment there can be risks and those risks have been explained to me and I assume those risks.

I acknowledge and understand that the therapist must be fully aware of my existing medical conditions. I have completed my medical history form as provided by my therapist and disclosed to the therapist all of those medical conditions affecting me. It is my responsibility to keep the massage therapist updated on my medical history. The information I have provided is true and complete to the best of my knowledge.

I authorize my therapist to release or obtain information pertaining to my condition(s) and/or treatment to/from my other caregivers or third-party payers.

I have read the above noted consent and I have had the opportunity to question the contents and my therapy. By signing this form, I confirm my consent to treatment and intend this consent to cover the treatment discussed with me and such additional treatment as proposed by my therapist from time to time, to deal with my physical condition and for which I have sought treatment. I have read the possible risks of treatment outlined above, but do not expect the practitioner to be able to anticipate and explain all possible risks and complications of treatment. I understand that at any time I may withdraw my consent and treatment will be stopped.

Children on the Premises

I understand that when I bring infants and/or children on to the clinic premises, I take sole responsibility for their safety. I understand that clinic staff cannot provide childcare supervision, that there is risk of injury from exposure to clinical equipment and I accept this risk.

Privacy Policy

The information received and collected about our clients/patients from their visit to Whole Family Health is strictly private and confidential. It is used and viewed only by the healthcare professionals and staff employed by Whole Family Health, 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 Whole Family Health (also, Whole Family Health 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 Whole Family Health premises. On occasion, Whole Family Health may use client/patient information to conduct clinical studies to help us improve upon services provided.

Appointment Policy

Welcome to Whole Family Health Wellness Centre. We are delighted to have you as a patient/ client and look forward to providing you with the highest quality care. In order to optimize your relationship with us, please take a minute to read our appointment policy.

Please note **a treatment room has been reserved for you**. With this in mind, if you are going to be more than 15 minutes late, please call to confirm availability. A 24 hour notice for cancelled or rescheduled appointments is necessary in order to avoid the cancellation fee. This allows us time to schedule another patient/ client that would also benefit from treatment. This appointment policy allows us to develop a mutual consideration and respect for our time and yours.

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

NATASHA MERCER, BRITTANY JANSEN
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Patient Information Release Request Form

I, _____ (please print name) understand that as part of Whole Family Health Wellness Centre's effort to provide me with the highest standard of integrated care, they may consult freely with other physicians and healthcare professionals, whose care I am under, regarding any of my medical treatments or relevant information. This could include the exchange of both verbal and written communications (including lab work).

I give full consent so that Whole Family Health Wellness Centre may share personal information and my confidential treatment plan with my other healthcare providers to better my care. _____ (Initial)

(*to be filled out by your Whole Family Health practitioner*)

The following is an authorization to provide Whole Family Health Wellness Centre with the following information:

- All recent lab work results
- All medical records
- All semen tests
- Other: _____

Alberta Health Care Insurance Plan (AHCIP) Number: _____

Doctor's Name: _____ Clinic Name: _____

Clinic Phone #: _____ Clinic Fax #: _____

I am nineteen years of age or older:

- Yes
- No

Client/Patient Signature: _____ Date: _____

Signature of parent or guardian (if applicable): _____

Thank-you for your prompt attention to this request. Please email information to info@wholefamilyhealth.ca
If you have any questions, please feel free to contact us.

Whole Family Health Wellness Centre Ltd.