Gaia Integrative Clinic
A division of 506703 NWT Ltd.
blending science and nature

Massage Therapy -Adult- Information and Consent Form

Please complete the following information in full:
Dr. Miss Mr. Mrs. Ms

First Name: _____

Middle Initial: _____

Last Name: _____

Address: _____
Suite/Apt./Unit No: _____
City: _____ Province: _____
Postal Code: _____

Gender: Male Female Date of Birth: _____
Month / Day / Year

Work Phone:_____ Extension: _____
Home Phone: _____ Mobile Phone: _____
Fax Number:_____ Other Phone: _____
E-mail: _____
Preferred contact method: _____
May we leave a message? _____

Primary Practitioner: _____
Family Doctor
Name: _____ Phone Number: _____
Address: _____

Emergency Contact
Name: _____ Phone Number: _____
Relationship: _____

How did you hear about Gaia Integrative Clinic?
Referral Website Newspaper Yellow Pages
Advertisement Friend/Family Other:_____

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I, the undersigned, voluntarily consent to the procedures and treatments provided to me at Gaia Integrative Clinic. I acknowledge and accept that there may be risks associated with these procedures and treatments, and that the risks will be explained to me in a manner that I can understand prior to any treatment. With this knowledge, I understand and acknowledge that I may ask questions regarding my treatment at any time and that I am free to withdraw my consent and discontinue participation in any procedures or treatments at any time. I further understand and acknowledge that no guarantees have been given to me by Gaia Integrative Clinic or any of its practitioners or personnel regarding cure or improvement of my condition.

I hereby consent to the collection, use and/or disclosure of my personal information for purposes related to the delivery of patient care and other related uses at Gaia Integrative Clinic. I understand that a record will be kept of the health services provided to me. I further understand that my personal information including this record will be kept confidential and will not be released to others unless so directed by me or my representative or otherwise permitted or required by law.

I hereby acknowledge and agree that I am financially responsible for all payments owing for services received at Gaia Integrative Clinic. I understand and agree that payment must be made at the time services are rendered and/or at the time products are purchased. Additionally, I am aware of the clinic's policy for missed or cancelled appointments. I agree to pay the charge of 50% of the cost of a scheduled visit should I miss or cancel or wish to change a previously scheduled appointment without providing a minimum of 24 hours advance notice.

_____

Patient's Name

_____ _____

Patient's Signature Date

P.O. Box 1401, 4907-47th Street, Yellowknife, NT, X1A 2P1•Phone: 867-873-3669• Fax: 867-873-5642
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Date: _____

Massage Therapy Health History Form

This information will help us to treat you more effectively and safely. Please note that this information is kept completely confidential, unless you give us permission to share it or if it is required by law. Your written permission will be required to release any information.

Your occupation: (Full time / part time)

Have you ever received massage therapy before? Y / N

Please indicate if any of the following conditions have affected you, past or present:

Cardiovascular	Past	Present
Heart disease	❒	❒
Heart attack	❒	❒
Stroke/CVA	❒	❒
High blood pressure	❒	❒
Low blood pressure	❒	❒
Varicose veins/clots	❒	❒
Pacemaker/implant	❒	❒
Chest pain	❒	❒
DVT	❒	❒
Other:_____	❒	❒

Respiratory	Past	Present
Asthma	❒	❒
Emphysema	❒	❒
COPD	❒	❒
Chronic cough	❒	❒
Bronchitis	❒	❒
Shortness of breath	❒	❒
Tuberculosis	❒	❒
Other:_____	❒	❒

Is there a family history of any of the above? Y / N

Skin	Past	Present
Eczema	❒	❒
Psoriasis	❒	❒
Acne	❒	❒
Warts	❒	❒
Canker Sores	❒	❒
Rash	❒	❒
Burns	❒	❒
Skin infection	❒	❒
Fungal infection	❒	❒
Scars	❒	❒
Other:_____	❒	❒

Digestive	Past	Present
Nausea	❒	❒
Diarrhea	❒	❒
Constipation	❒	❒
IBS	❒	❒
Crohn's disease	❒	❒
Diverticulitis	❒	❒
Appendicitis	❒	❒
Stomach Pain	❒	❒
Other: _____	❒	❒

Infections	Past	Present
HIV/AIDS	❒	❒

Women	Past	Present
Menstrual difficulties	❒	❒

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Hepatitis	❒	❒
STI's	❒	❒
Other:	❒	❒

Pregnancy	❒	❒
Birth Control	❒	❒
Gynecological concerns:	❒	❒

Bone/Joint/Muscle	Past	Present
Strain	❒	❒
Sprain	❒	❒
Fracture	❒	❒
Dislocation	❒	❒
Osteoarthritis	❒	❒
Rheumatoid arthritis	❒	❒
Other concerns:	❒	❒
	❒	❒

Other conditions		
Neurological disease	❒	❒
Diabetes	Past	Present
Kidney disease	❒	❒
Liver disease	❒	❒
Hyper / hypothyroidism	❒	❒
Disc problems	❒	❒
Depression	❒	❒
Mental illness	❒	❒
Addiction	❒	❒
Anxiety	❒	❒
Nervousness	❒	❒
Cancer	❒	❒
(type/stage:)	❒	❒
Any other conditions or concerns:	❒	❒

Head/Neck	Past	Present
Head trauma	❒	❒
Whiplash	❒	❒
Fainting	❒	❒
Dizziness	❒	❒
Vision problems	❒	❒
Vision loss	❒	❒
Hearing loss	❒	❒
Ringing in ears	❒	❒
Jaw pain	❒	❒
Headaches	❒	❒
Migraines	❒	❒
Epilepsy	❒	❒
Numbness	❒	❒

Have you ever been in a motor vehicle accident? Date/injuries:

Have you ever had any surgeries? Y / N (Date/results:)

Do you have any internal pins, wires, or implanted devices? Y / N
Are you affected by headaches? Y / N How often?
How many hours do you sleep on a regular night?
What is your physical activity level? (circle) low / low-moderate / moderate / moderate-high / high
How would you rate the level of stress in your life? (circle) low / low-moderate / moderate / moderate-high / high
How would you rate your level of stress at work? (circle) low / low-moderate / moderate / moderate-high / high
How do you manage stress?

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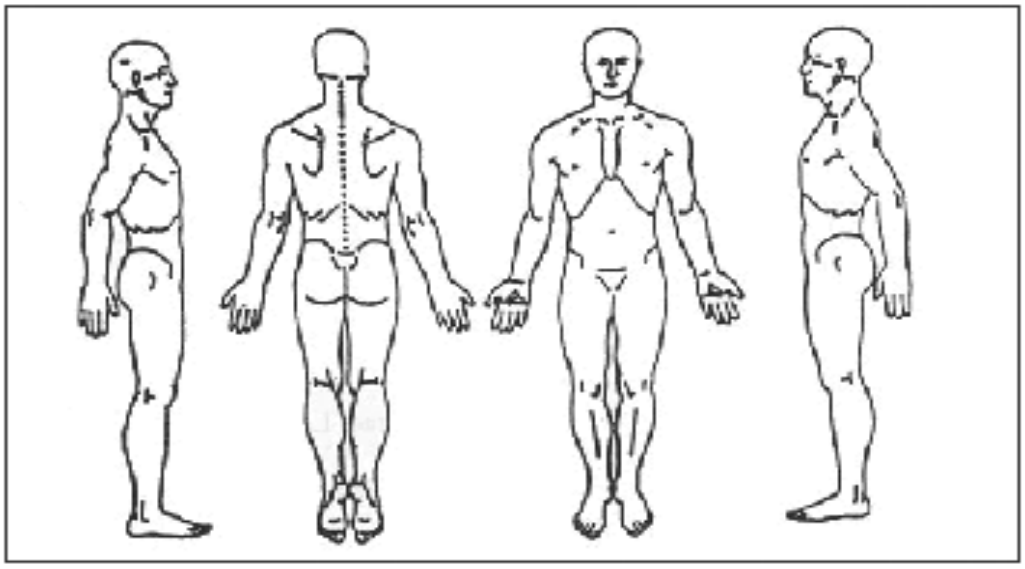
Do you take any medications / supplements? Y / N

Do you have any allergies/sensitivities? (environmental, food, medications, oils, essential oils, etc.) Y / N

Please list the reasons you are seeking Massage Therapy today, in order of importance to you:

1.) _____
2.) _____
3.) _____
4.) _____

Please indicate any areas of pain or discomfort on the drawings below:



f applicable mark:
↑ - Ache/Dull pain
) - Pins & Needles/Tingling
3 - Burning
N - Numbness
) - Discomfort

If applicable, list any areas that you would not like treated today:

Any further comments:

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I have answered these questions truthfully and thoroughly to the best of my knowledge. I will inform my therapist of any changes or updates to my medical history. I do not have any additional injuries or health conditions I have not mentioned here that would respond negatively to Massage Therapy. I understand that I have entered a safe space for healing and I will be in control of my treatments.

Signature_____

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