urban wellness
HOLISTIC HEALTHCARE

Rhiannon Hughes, RMT
Consent for Massage Therapy

I understand that to provide me with Massage Therapy, Rhiannon Hughes, RMT will collect some personal health information about me. I agree to Myles and Rhiannon collecting, using, and retaining personal information about me as set out in the Privacy Policy. The information I give on my health history form is accurate and I understand that my information will remain confidential unless allowed or required by law. Any questions I have about this have been answered to my satisfaction, and I am aware that a copy of the privacy policy is available for viewing at the front desk.

I understand that only if I check off the following boxes will I receive the following:

□ I would like to receive newsletters and other informational mailings from Myles or Rhiannon.
Email address: _____

I understand that my massage treatment includes review of my health history, assessment, massage, and self-care advice. Only the areas of my body that I agree to be treated by my Massage Therapist will be addressed and it will only be those areas that will be uncovered during my treatment. As a client, I have the right to clarify and ask questions concerning my assessment and treatment, and also to stop, discontinue, or change the treatment at any time.

Massage Therapy fees are as follows:

30 minute treatment	60 + HST = 67.80
45 minute treatment	70 + HST = 79.10
60 minute treatment	90 + HST = 101.70
90 minute treatment	140 + HST = 158.2

Methods of payment are **cash**, **personal cheque**, **debit/credit**, and **email money transfer**.
Cancellation of Massage Therapy treatment is required **24 hours** before the scheduled appointment time. **Client may be responsible for the fee of any cancelled or missed treatment that does not adhere to this policy.**

I have read and understand the above information and give my consent to receive treatment with Rhiannon Hughes, RMT.

Name: _____Signature: _____Date: dd/mm/yy

CONFIDENTIAL HEALTH HISTORY FORM

An accurate health history is important to ensure that we treat you safely and effectively. This form must be updated annually.

First Name:_____ Last Name: _____

Address: _____ Tel. Home: _____Cell: _____

City: _____Prov: ____ Postal Code: _____ Tel. Work: _____Email: _____

Date of Birth: DD/MM/YY Gender: M/F Occupation: _____

Primary Health Care Physician: _____ □ Health Practitioner's Referral: _____

Address: _____ □ Other Referral: _____

Tel. No: _____ Emergency Contact Person: _____

1st Massage Therapy Treatment? Y/N Emergency Contact Tel: _____

General Health Status: _____ How did you hear about me? _____

Primary Complaint : _____

Please ✓ any following conditions that you are experiencing past or present.

Soft Tissue/Joints ie pain, stiffness, numbness, twitching etc.

Past/Present

□ □ neck _____
□ □ shoulder _____
□ □ upper back _____
□ □ mid back _____
□ □ low back_____
□ □ arms _____
□ □ chest _____
□ □ legs _____
□ □ knees _____
□ □ hips _____
□ □ other_____

History of Headaches

□ tension
□ migraines
□ tooth/jaw/ear pain
□ head trauma/date: _____
□ history of headaches/type:_____
□ other: _____

Accident/Injury

Date: _____
Symptoms: _____
_____
_____
Physical Limitations: _____
_____
_____

Surgery:

Date:_____Type:_____
Current symptoms: _____

Current Medications/Conditions:

_____
_____
_____
_____

□ **Medic Alert Bracelet**

Respiratory

□ chronic cough
□ shortness of breath
□ bronchitis
□ asthma
□ emphysema
□ pneumonia
□ sinus problems
□ family history of any of above:
_____

Cardiovascular

□ high blood pressure
□ low blood pressure
□ heat attack (date: _____)
□ phlebitis/DVT
□ stroke/CVA (date: _____)
□ □ migraines
□ pulmonary emboli
□ pacemaker
□ heart disease
□ angina
□ chronic congestive heart failure
□ family history of any of above:
_____

Infectious Disease

□ hepatitis
□ infections skin condition
□ tuberculosis
□ HIV
□ other: _____

Gastrointestinal

□ irritable bowel syndrome
□ colitis
□ gastroenteritis
□ crohn's disease
□ constipation
□ other: _____

□ **Pins/Wires/Prosthetics:**

_____

Skin:

□ skin condition: _____
□ bruise easily
□ herpes
□ varicose veins
□ athlete's foot
□ loss of sensation

Other:

□ neurological conditions: _____
□ epilepsy
□ diabetes/onset: _____
Type_____
□ allergies: _____
□ cancer: _____
□ arthritis: _____
RA/OA/Other: _____
where: _____
□ family history of arthritis
□ vision/hearing loss
□ insomnia
□ haemophilia
□ kidney/bladder problems:_____
□ osteopenia
□ osteoporosis
□ vertigo
□ mental illness: _____
□ other: _____
□ Smoker:

Women

□ pregnant/due date: _____
□ gynecological conditions:
_____
□ breast pain
  - Cysts
  - Breast Surgery:_____

Are you currently receiving treatment from any other healthcare professional?

YES/NO/Explain: _____