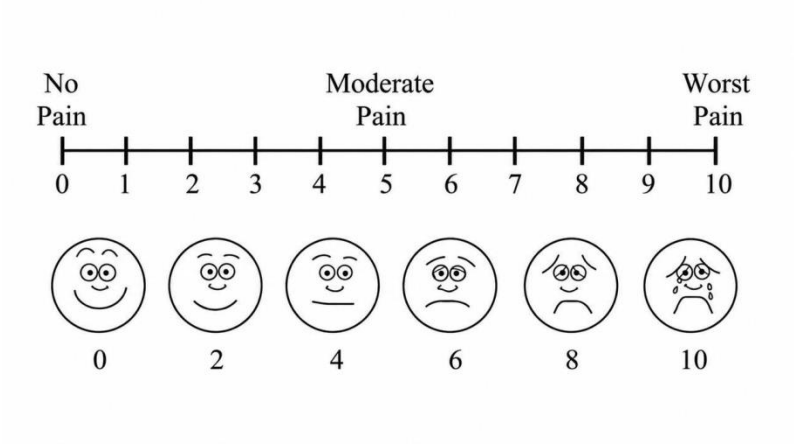
Massage Therapy Informed Consent and Privacy Consent

First Name:	
Last Name:	
DOB:	

Reason for today's visit:

_____

Using the following Pain Scale, rate your pain:



Health Information:

Are you currently under the care of a healthcare professional?

☐ Yes☐No If yes, please explain:

_____

Medical History: Please check all conditions that apply:

Cardiovascular:

☐ High Blood Pressure ☐Low Blood Pressure ☐Heart Disease ☐Heart Attack

☐ Stroke ☐Pacemaker ☐VaricoseVeins ☐No

2. **Respiratory**

☐ Asthma ☐Chronic Bronchitis ☐Arthritis ☐ Osteoarthritis

☐ Osteoporosis ☐Fibromyalgia ☐Chronic Pain ☐Back Pain

☐ Neck Pain ☐Joint Replacement ☐Neurological ☐Migraines

☐ Headaches ☐Concussion ☐Numbness ☐ Diabetes

☐ Thyroid Disorder ☐High Cholesterol ☐No

3. Mental Health

☐ Anxiety ☐Depression ☐Stress-Related Condition ☐No

4. Cancer and Other Conditions

☐ Cancer ☐Autoimmune Disorder ☐Infectious Disease

☐ Skin Condition ☐No ☐Other:

5. Pregnancy

☐ Not Applicable ☐Pregnant Due Date: _____

Informed Consent to Massage Therapy Treatment:

Iunderstandthatmassagetherapyinvolvestheassessmentandtreatmentofthesofttissues, muscles, fascia, tendons, ligaments, and joints of the body through various techniques that may include:

- Massage and soft tissue manipulation
- Stretching techniques
- Joint mobilization
- Triggerpointtherapy
- Myofascial techniques
- Hydrotherapy applications (where applicable)
- Therapeuticexerciserecommendations

The massage therapist has explained:

- The nature of the proposed treatment
- The expected benefits
- Possible risks and side effects
- Alternative options, where appropriate
- My right to ask questions

Iunderstand thatmassage therapymay result intemporary sideeffects such as:

- Mild soreness or tenderness
- Bruising
- Fatigue
- Headache
- Temporary increase in symptoms

I understand that massage therapy is not a substitute for medical diagnosis or treatment and that no guarantee has been made regarding treatment outcomes.

Client Responsibilities:

I confirm that I have provided accurate and complete information regarding my health history,including:Medical conditions:

- Injuries
- Surgeries
- Medications
- Allergies
- Pregnancy status (if applicable)

I agree to inform my massage therapist of any changes in my health condition that may affect my treatment.

Ongoing Consent:

I understand that consent may be withdrawn at any time and that I may request modification or termination of treatment during any appointment.

I understand that treatment plans may change based on assessment findings and my current condition. The therapist will discuss significant changes with me and obtain my consent before proceeding.

Consent to Assessment and Treatment:

I voluntarily consent to assessment and massage therapy treatment provided by the Registered Massage Therapist.

My personal health information will be protected in accordance with applicable privacy legislation and professional standards.
I understand that I may access or request correction of my records, subject to legal requirements.

I consent to the collection, use, and disclosure of my personal health information as described above.

Signature(please use your First name and Last name): _____ **Date** _____