Justine Blainey Wellness Centre

220 Wexford Road, Unit 2 Brampton, ON L6Z 4N7 (905) 840-9355

Client Information

Name: _____ Date: _____
Address: _____
City:_____Province:_____ Postal Code:_____
Home Phone:_____Business Phone:_____
Cell Phone: _____ E-mail:_____
Date of Birth: _____Occupation: _____
Physician's Name and Address: _____
Emergency Contact (Name/Telephone): _____
How did you hear about the Wellness Centre? _____
E.g. newspaper, friend, gift certificate, word of mouth, outside sign, etc.
Primary complaint: _____

Please indicate if you have any of the following conditions:

Head/Neck:
□ headaches □ head injury
type:_____ □ hearing problems
□ vision problems □ earaches
□ contact lenses

Respiratory:
□ chronic cough □ smoking
□ shortness of breath □ heavy □ light
□ asthma □ bronchitis
□ emphysema □ allergies
□ sinus problems

Cardiovascular:
□ high blood pressure □ low blood pressure
□ poor circulation □ phlebitis
□ heart disease □ heart attack
□ pacemaker
□ chronic congestive heart failure
□ varicose veins (Dr. diagnosed)? _____

Skin:
□ sensitive skin □ cold sores
□ plantar warts/ □ rashes
athlete's foot □ bruise easily
□ eczema/psoriasis □ loss of sensation
where? _____ where? _____

Reproduction:
Menstruation □ menopause
□ painful □ pregnant
□ heavy due date: _____
□ scant □ PMS

Infectious Conditions:
□ tuberculosis □ HIV/ AIDS
□ hepatitis type: _____

Of special note: e.g., pins, wires, artificial limbs, special equipment i.e. wheelchair, walker etc.
_____

Muscle Strain:
□ neck □ hand
□ upper back □ abdomen
□ mid back □ thigh
□ lower back □ lower leg
□ shoulders □ foot
□ arm/forearm

Joint Conditions:
□ neck □ back
□ shoulder
□ elbow/wrist
□ fingers
□ hip □ ankle
□ knee □ toes

Digestive/urinary:
□ difficult digestion □ poor appetite
□ excessive appetite □ constipation
□ irritable bowel syndrome □ ulcers
□ liver/gallbladder □ Crohn's/colitis
□ diabetes, type: _____ □ chronic diarrhea
onset: _____ □ other: _____

Other Conditions:
□ hemophilia □ epilepsy
□ fibromyalgia □ carpal tunnel syndrome
□ osteoporosis □ tendonitis
□ scoliosis □ bursitis
□ cancer date: _____ type: _____
□ herniated disc where? _____
□ arthritis □ family history of arthritis
□ other: _____

Surgery/ Injury:
Type: _____
Date: _____
Type: _____
Date: _____

Current medications and condition treated:
_____
_____

Previous massage experience	yes	no
Regular exercise	yes	no
Good sleeping patterns	yes	no
Physiotherapy	yes	no
Chiropractor	yes	no

I understand that the following information is confidential and correct to the best of my knowledge.

Signature: _____ Date: _____

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Consent to Assessment Process and Treatment

I, _____ (name), have requested assessment by this Registered Massage Therapist (RMT) and/or other JBWC Registered Massage Therapists. Following a discussion and review of assessment findings, I have requested treatment by this Registered Massage Therapist (RMT) and/or other JBWC Registered Massage Therapists for treatment of the areas identified below, for the purposes of treating the following clinical indications:

_____

_____

As part of my therapeutic assessment and treatment, I am aware that the RMT may touch the following area(s) of my body if needed and discussed and consented prior [client to place **initials** (not check marks) in relevant areas below]:

____ **All areas needed**	____ Breast(s)	____ Inner Thigh(s)
____ Neck	____ Chest Wall Muscles	____ Legs
____ Shoulders	____ Back	____ Feet
____ Arms	____ Buttocks (gluteal muscles)	

The RMT has explained the following to me and I fully understand the proposed assessment and treatment including [client to place **initials** (not check marks) to indicate that the items below were addressed]:

____ The nature of the assessment and treatment, including the clinical reason(s) for the assessment and treatment of the above area(s) and the draping methods to be used

____ The expected benefits of the assessment and treatment

____ The potential risks of the assessment and treatment

____ The potential side effects of the assessment and treatment

____ Alternative courses of action

____ Likely consequence of not having the treatment

____ That consent is voluntary

____ That I can withdraw or alter my consent at any time

____ **All above reviewed**

I voluntarily give my informed consent for the assessment and treatment as discussed and outlined above.

Client Name (print): _____

Client Signature: _____

Date: _____

RMT Signature: _____

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MEDICAL RECORDS RELEASE FORM

I, _____, hereby authorize the release of my medical/ massage therapy record or copies of the same to such parties that the therapist may deem necessary as it relates to my case, and do hereby hold harmless anyone for such actions.

Patient Signature: _____

Witness: _____

Date: _____

REGISTERED MASSAGE THERAPY FEE POLICY

The fees for massage therapy treatments are:

Massage Therapy

Length of Treatment	Adult Fees	HST	Total Fee (includes HST)
30 minutes	$66.37	*$8.63*	*$75.00*
45 minutes	$79.65	*$10.35*	*$90.00*
60 minutes	$97.35	*$12.65*	*$110.00*
90 minutes	$132.75	*$17.26*	*$150.00*

*I am aware that I am responsible for payment by Cash, Debit, Visa, MasterCard, or Cheque ($30 charge will be applied for NSF cheques)

*I understand that if I miss or cancel my appointment less than 24 hours ahead of time the fee will be equal to the fee for massage for that time. Example: one hour massage missed fee is $110. Credit card number or pre pay will be expected.

I also understand that if I am late for my appointment, my treatment will be reduced accordingly.