Eunice Mooney

Registered Massage Therapist (RMT)
Certified Lymphatic Therapist (CLT)

Eunique
MASSAGE & FITNESS

Date: _____ Name: _____

Phone: (H)_____ (W)_____ (C)_____

Address: _____ Postal code: _____

Email: _____ DOB: _____

How did you hear about me? _____

Your:
Occupation: _____ Physician: _____

Chiropractor: _____ Physiotherapist: _____

Have you been to a Massage Therapist before? _____ When? _____

Why? _____

_____

Is there any specific area you would like me to pay special attention to today? _____

Please indication by marking an (X), any of the following conditions you may have had.
Please ***circle*** the ones you currently have.

( ) Headache	( ) Tendonitis	( ) Cancer
( ) Migraine	( ) Osteoporosis	( ) Respiratory Conditions
( ) Skin Rashes	( ) Spasms/Cramps	( ) High/Low Blood Pressure
( ) Acne	( ) Edema(swelling)	( ) Aneurism
( ) Warts	( ) Whiplash	( ) Heart Condition
( ) Digestive Disorders	( ) Carpal Tunnel	( ) Thyroid Problems
( ) Diabetes	( ) Osteomyelitis	( ) Pins/Plates or Surgical Implants
( ) Depression	( ) Varicose Veins	( ) Hearing Impaired
( ) Circulatory Conditions	( ) Fibromyalgia	( ) Osteoarthritis
( ) Anxiety	( ) Multiple Sclerosis	( ) Rheumatoid Arthritis
( ) Ulcer	( ) Hiatal Hernia	( ) IUD

( ) Allergies (pls list) _____

Are you currently pregnant? _____ if so, when is your due date: _____
Have you been diagnosed with any other medical condition(s) that are not listed here. If so,

please list them: _____

_____

Are you currently under any medical supervision for any of these conditions? _____

_____

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MEDICAL HISTORY: (beginning with the most recent)

Date	Injuries, Surgeries & Major Illnesses	Treatment

MEDICATIONS: (please list)

Name	Reason for taking	How long

Do you have any further questions/concerns or comments?

_____

_____

_____

_____

Please note that email and contact information will be used *ONLY* to forward educational information and information concerning upcoming events.
Your record is held in the utmost confidence.

INFORMED CONSENT TO MASSAGE THERAPY TREATMENT

I understand that the Eunice Mooney, my Therapist, is providing services within her scope of practice as defined by the Massage Therapy Association of Alberta (MTAA).

I hereby consent to my Therapist to treat me with massage therapy for the above noted purposed including such assessments, examinations and techniques which may be recommended by my 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 a result of treatments. 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 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 further agree to allow my Therapist to take pictures of me for the purpose of analyzing and documenting my treatment requirements. The pictures will remain at my Therapist's office and will not be shown to or discussed with anyone other than medical practitioners.

I understand that my Therapist's time is valuable and others are waiting for appointments, therefore I will try my best to give 24 hour cancellation notice or I may be charged for that appointment. I know that everyone's schedule is important and I understand that if I am late for an appointment the treatment will be delivered in the remaining time allotted.

REGISTERED Massage Therapists must have a minimum of 2200 hours of education, pass written and practical Board exams, obtain continuing education, carry insurance and abide by a professional code of ethics. RMT's are recognized by most insurance companies and carry provider numbers so that you may be reimbursed. Sometimes insurance carriers require a prescription from your Medical Doctor.

I have read the above noted consent and I have had the opportunity to question the contents and my therapy treatment. By signing this form, I confirm to treatment and intend this consent to cover the treatment discussed with me and such additional treatments as proposed by my Therapist from time to time, to deal with my physical condition and for which I have sought treatment. I understand that at any time I may withdraw my consent and treatment will be stopped.

_____ _____

Client Name (please print) Signature of Client/Guardian

_____

Date Signed