Informed Consent for Massage Therapy

I understand that the Massage Therapist providing treatment will remain within their scope of practice as defined as by the Massage therapy associations of Alberta. I acknowledge that my massage therapist is not a Physician and is unable to Diagnose illness or disease, or any other physical and mental disorder. I understand that massage therapy is not a replacement or substitute for medical examination. Risks associated with massage can include, but are not limited to: Short-term muscle soreness, exacerbation of undiagnosed injury, superficial muscle bruising, I hereby release the Massage therapist, The Massage company, and any third-party facilitator of any and all liability from injuries that may occur during a massage session.

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I understand and acknowledge that my massage therapist must be fully aware of and all pre-existing health conditions and medications as these can have a direct impact on massage treatment. I understand that it is my responsibility to keep the massage therapist up to date on my medical history. The information I have provided is true and complete to the best of my knowledge.

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I have read the noted consent and have had the opportunity to ask questions about my treatment.
I confirm my consent for treatment and intend this consent to cover this treatment as discussed and any additional treatments hereafter. I understand at any time the massage therapist, or I can withdraw consent and stop treatment immediately, at any time.

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** I consent to having my glutes treated in my massage therapy sessions. I understand at any point I can withdraw my consent to this treatment.

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CANCELLATION POLICY

If you are unable to attend your appointment for any reason, we require a 24 hour notice to cancel so that we have the opportunity to contact those on the waitlist.

Failure to give this notice will result in a <u>100%</u> charge of treatment.

If appointments are repeatedly cancelled without notice this may result in termination as a patient with our massage therapist.

Printed name _____ Signed name_____

Date_____

Massage Therapy Intake & Health History

Name_____ Date_____

Address_____

Email Address_____ Ph: _____

Date of birth (DD/MM/YYYY)_____

Emergency contact (Name/Ph Number) _____

Reason for Treatment today _____
Is this a workplace related injury or a Motor vehicle accident injury? _____

Current Medications and what they are Rx for: _____
_____

Previous surgeries or Injuries _____
_____

Diagnosed illness(s) and treatments _____
_____

Are you under care for any of the following?

High/low Blood pressure	Varicose Veins	Skin Conditions	Osteoporosis
Arthritis or R/A or O/A	Fibromyalgia	Epilepsy	Whiplash
Migraines/Chronic Headache	Diabetes	Cancer	Palliative Care

**If this treatment is to be done In-home please provide parking information. Please note that any parking costs will be added to the cost of your treatment. **

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This form is required to be updated yearly, or if there are any changes to your health.