lakeside
Physiotherapy & Massage

307 Robinson St. Oakville, ON L6J 1G7
Tel: 289 805 2252 Fax: 289 805 2253
info@lakesidephysiomassage.com

MASSAGE THERAPY INFORMED CONSENT

I, _____, understand the professional intentions of the treatment about to be received. I am fully aware that Massage Therapy, Acupuncture or Traditional Chinese Medicine is not a substitute for medical treatment or medications and that the Massage Therapist does not diagnose illness or disease and does not prescribe medications. I also understand that spinal manipulations are not in the scope of practice of massage therapy.
I understand the treatment procedure that has been explained to me including the benefits, risks, and contraindications. I am aware that I may alter or stop the treatment at any time.
I have informed my therapist of all my known medical conditions, medications and physical condition and will update the therapist on any changes as soon as possible.

Signature of patient or guardian: _____DATE: _____

CONSENT FOR COLLECTION, USE AND DISCLOSURE OF PERSONAL INFORMATION

Please note that all healthcare providers subcontracted by Lakeside Physiotherapy & Massage, at this location, will have access to your patient files, which will be kept confidential amongst them unless otherwise agreed upon in writing by the patient.

All personal information, including medical information, collected will remain safe and secured and will NOT be shared with any other healthcare providers who are NOT subcontracted by LAKESIDE PHYSIOTHERAPY & MASSAGE unless otherwise agreed upon by in writing by the patient.

Information may be collected via phone, personal interview, direct examination, transfer of medical information from other health care professionals, and third parties including insurance companies.

Personal information will only be seen by the healthcare professionals at the aforementioned clinic office. In an event where personal information is required by insurance companies, regulatory bodies, and health care professionals, verbal consent will be obtained before information is transferred.

I, hereby consent to the collection, use, and disclosure of my personal information within LAKESIDE PHYSIOTHERAPY & MASSAGE.

Signature of patient or guardian: _____

CANCELLATION POLICY

I understand that **24 hours' notice** is required in order **to cancel** or **reschedule an appointment**. In the event that I miss an appointment, **a fee for that scheduled appointment will apply.** **Signature: _____**

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Health History Form

Date: **Updated Date:** **Updated Date:**

An accurate health history is important to insure that it is safe for you to receive massage treatment. This information is confidential and can only be released with your written authorization. Any changes to your health status should be communicated to your therapist as soon as possible.

First Name: Last Name:

Address: City: Province: Postal:

Date of Birth: Cell Phone Number:

Email: How did you hear about Lakeside?

Would you like to receive email communication for appointment confirmation and promotions? YES ☐ NO ☐

Primary Complaint: _____

Please check any conditions below you have or have had in the past

HEAD/NECK
[ ] Vision Problems
[ ] Vision Loss
[ ] Contact lenses
[ ] Ear problems
[ ] Hearing loss
[ ] Thyroid
[ ] TMJ
[ ] Headaches

RESPIRATORY
[ ] Chronic cough
[ ] Bronchitis
[ ] Asthma
[ ] Emphysema
[ ] Short breath
[ ] Breathing difficulties

CARDIOVASCULAR
[ ] High blood pressure
[ ] Low blood pressure
[ ] CCHF
[ ] Heart disease
[ ] Heart attack
[ ] Myocardial infarction
[ ] Phlebitis
[ ] Varicose veins
[ ] Poor circulation
[ ] Stroke
[ ] CVA
[ ] Pacemaker/other devices
[ ] Hemophilia

SKIN
[ ] Skin conditions
[ ] Skin irritations
[ ] Bruise easily

OTHER CONDITIONS
[ ] Loss of sensation
[ ] Diabetes
[ ] Allergies
[ ] Anaphylaxis
[ ] Arthritis
[ ] Epilepsy
[ ] Cancer
[ ] Kidney
[ ] Gall Bladder
[ ] Constipation
[ ] Other: _____

INFECTIONS
[ ] Herpes
[ ] Hepatitis
[ ] Warts
[ ] TB
[ ] HIV, AIDS
[ ] Other: _____

WOMEN
[ ] Pregnant
Due:_____ Week:____
First child? _____
Risks? _____
Children? _____

SOFT TISSUE JOINT DISCOMFORT
[ ] Neck
[ ] Low back
[ ] Mid back
[ ] Upper back
[ ] Shoulders
[ ] Arms
[ ] Legs
[ ] Knees
[ ] Other: _____

Doctor: Address: Phone:

Medications: Conditions being treated:

Injuries: Nature: Date:

Surgery: Nature: Date:

Other conditions (digestive, gynecological etc.):

Of special note (presence of pins, plates, wires, artificial joints, special equipment like wheelchair/ walker/cane etc.):

Please SIGN & COMPLETLE For Claims SUBMITTED ON YOUR BEHALF To INSURANCE Co.

Name of Medical Insurance Group _____	
SIGNATURE: _____	
Policy/Plan Number:	ID Number:
Percentage Covered:	To Maximum of $

I understand all the information on this form and have given the correct information to the best of my ability.

Client Signature: _____ **Verification Date: _____**