# Olivier Pere, R.M.T

***Move Better – Feel Better – Perform Better***

## CLIENT INFORMATION AND CONSENT FORM

FYI: An accurate health history ensures that it is safe for you to receive a massage treatment, and helps the therapist determine a proper treatment plan. When your health status changes in the future, please let us know. All information gathered on this form is confidential. Your written authorization is legally required before any of this information can be released.

Name: _____

Address: _____

_____ Postal Code _____

Today's date: _____ Date of Birth: _____

Phone Numbers: Home: _____ Cell: _____ Work: _____

Email Address: _____

Emergency contact name: _____ Cell: _____

Occupation: _____

How did you hear about us? _____

Physician's name/Phone number & address (if you know it) _____

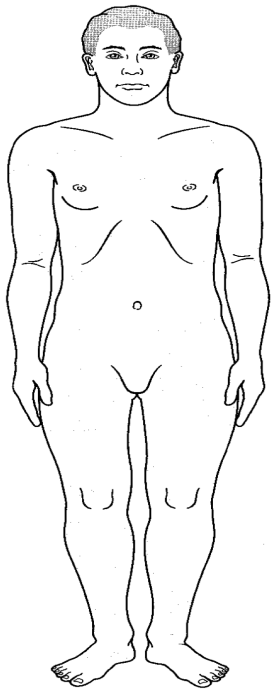
_____

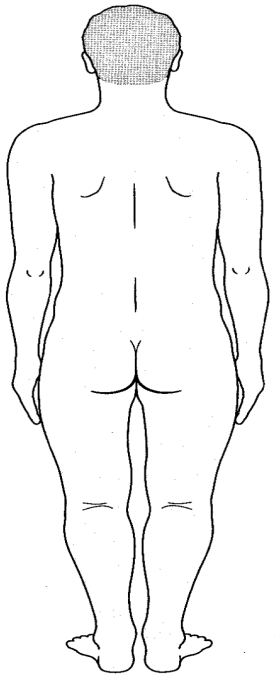
Insurance Provider: _____ Plan/Group/Contract # _____ Certificate #: _____

What is your major area of concern that you would like treated? (Write below & circle the areas)

_____

_____





On the body diagrams to the left, please circle the areas that you are experiencing problems/pain/stiffness etc. If you are experiencing pain in one area and feeling it elsewhere, please indicate this with arrows.

Please indicate all conditions you have experienced. Mark **C** for current or **P** for past.

### Joint/Soft Tissue Discomfort:

_____ Arms
_____ Upper Back
_____ Mid Back
_____ Lower Back
_____ Degenerative Discs
_____ Feet
_____ Hands
_____ Hips
_____ Jaw
_____ Knees
_____ Legs
_____ Neck
_____ Osteo Arthritis
_____ Rheumatoid Arthritis
_____ Limitation of Movement
_____ Shoulders
In which joints: _____
Other _____

### Cardiovascular:

_____ High Blood Pressure
_____ Low Blood Pressure
_____ Coronary Heart Disease
_____ Heart Attack
_____ Stroke / CVA
_____ Pacemaker
_____ Heart Murmur
_____ Palpitations
_____ Varicose Veins
_____ Swelling of the Ankles
_____ Poor Circulation

### Eye, Ear, Nose, Throat:

_____ Allergies
_____ Frequent Colds
_____ Glasses or Contacts
_____ Hearing Loss
_____ Sinus Infection
_____ Swollen Glands

### Skin:

_____ Rashes
_____ Itching
_____ Bruise Easily
_____ Dryness
_____ Boils
Other _____

### General Symptoms:

_____ Fainting
_____ Dizziness
_____ Loss of Sleep
_____ Fatigue
_____ Nervousness
_____ Sudden Weight Loss/Gain
_____ Numbness
_____ Paralysis
_____ Headaches (Tension)
_____ Migraines

### Infectious:

_____ Hepatitis
_____ Tuberculosis
_____ Human Immunodeficiency Virus (HIV)
_____ Herpes
_____ Cold
_____ Athlete's Foot
_____ Warts
Other _____

### Digestive:

_____ Poor Appetite
_____ Belching/Gas
_____ Constipation
_____ Diarrhea
_____ Nausea
_____ Ulcer
_____ Vomiting
_____ Diabetes (Type 1 or 2)

### Respiratory:

_____ Chronic Cough
_____ Bronchitis
_____ Asthma
_____ Hay Fever
_____ Difficulty Breathing
_____ Smoking
_____ Emphysema
_____ Pneumonia

### For Women:

### Reproductive:

_____ Pregnant
Due date _____
_____ Painful Menstruation
_____ Heavy Flow
_____ Irregular Cycle
_____ Menopausal
_____ Pre-menopausal
_____ Post-menopausal
_____ Birth control
type _____

## Lifestyle Questions

**Do you take prescribed medications:** Yes No
Frequency: _____
Type: _____
_____
_____

**Regular exercise:** Yes No

Type: _____ Frequency: _____

**High Stress** Yes No

**Allergies/Hypersensitivities:** _____
_____

**Have you received care from any of the following? (circle)**

- Physiotherapist
- Chiropractor
- Massage therapist
- Naturopath
- Other:

**Have you had surgery in the past?** If yes, for what? _____

**Have you had any fractures/sprains in the past?** If yes, where? _____

**Have you had any serious illnesses in the past?** If yes, what? _____

**Did the current injury result from a motor vehicle accident or workplace injury?** Yes No

*I attest that the information I have provided is true and complete to the best of my knowledge.*

*I understand the information I have provided on this form is confidential and will not be released without my written consent.*

*I consent to therapeutic massage treatment by the therapist Olivier Pere.*

*I hereby assign benefits payable for the eligible claims to the Provider responsible for submitting my claims electronically to the group benefits plan and I authorize the insurer/plan administrator to issue payment directly to the Provider. In the event my claim(s) are declined by the insurer/plan administrator, I understand that I remain responsible for payment to the Provider for any services rendered and/ or supplies provided.*

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## INFORMED CONSENT TO MASSAGE THERAPY TREATMENT

I understand that the massage therapist is providing massage therapy services within their scope of practice as defined by the Certified Registered Massage Therapist Association.

I hereby consent for my therapist to treat me with massage therapy for the above noted purposes 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, 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 to the results of the treatment. 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. I have completed my medical history form as provided by my therapist and disclosed to the therapist all of those 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, only when necessary and only with a prior verbal request.

I have read the above noted consent and I have had the opportunity to question the contents and my therapy. By signing this form, I confirm my consent to treatment and intend this consent to cover the treatment discussed with me and such additional treatment 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.

**WHEN YOU BOOK AN APPOINTMENT, THAT TIME IS SET ASIDE FOR YOU, AND MISSED APPOINTMENTS PREVENT US FROM ACCOMMODATING OTHER CLIENTS. IF YOU DO NOT SHOW UP FOR YOUR SCHEDULED APPOINTMENT OR IF YOU WANT TO RESCHEDULE, AND YOU HAVE NOT NOTIFIED US AT LEAST 24 HOURS IN ADVANCE, YOU WILL BE REQUIRED TO PAY THE FULL COST OF THE TREATMENT AS BOOKED. MISSED APPOINTMENT FEES ARE NOT TO BE DIRECT BILLED. WE CAN GIVE YOU A RECEIPT FOR THE SERVICE YOU HAVE LATE CANCELLED OR MISSED THAT YOU ARE WELCOME TO SUBMIT TO YOUR INSURANCE PROVIDER.*

Patient Name _____

Signature of Patient/Guardian _____

Date Signed _____