Massage Therapy Waiver and Consent Form

I understand that the massage I receive is provided for the basic purpose of relaxation, stress reduction, and relief or muscular tension. I further understand that the massage should not be construed as a substitute for medical examination, diagnosis, or treatment and that I should see a physician, chiropractor, or other qualified medical specialist for mental or physical ailment that I am aware of.

I understand that massage therapists are not qualified to perform skeletal adjustments, diagnose and/or prescribe, and that nothing said in the course of the session should be construed as such.

Because massage is contraindicated under certain conditions, I affirm that I have stated all my known medical conditions and answered all questions honestly. I agree to keep the therapist updated as to any changes in my medical profile and understand that there shall be no liability on the therapist's part should I forget to do so.

Date_____

_____
Patients signature

Name:_____
(Please Print)

I,_____, hereby understand that the practice of Massage Therapy is a separate and distinct business entity than therapy from the practice of Chiropractic provided by Dr. Christopher M, Hankins BSc.,D.C. of the Bridgeland Sport & Spine, at 202 8A Street NE

_____
Patients signature

Name:_____
(please print)

BRIDGELAND SPORT & SPINE
EXPLANATION OF FEES

The purpose of this page is to clarify your financial responsibilities so that we focus our efforts on helping you achieve optimal results in the shortest possible amount of time.

Massage Length:	Cost:
30 minutes	$50.00
45 minutes	$65.00
60 minutes	$80.00
90 minutes	$120.00

Forms of Payment:
Patients are responsible for full payment at the time services are rendered. We accept Interac, Visa, MasterCard, personal cheque and cash. Any credit arrangements must be authorized in advance by the Massage Therapist
.

Third Party Insurance Coverage:
Third party insurance (extended health care benefits) coverage varies from plan to plan. Please check with your provider for specific coverage details.

All professional services rendered are charged to the patient receiving care. We will supply you with statements, reports, or other documents for a fee, if applicable, as outlines above, to help you receive reimbursement from a third party.

Missed/Cancellation Appointment Policy

Our office requires 12 hour notice cancellation of Massage Therapy Appointments.
Appointments missed or cancelled without sufficient notice will be charged the cost of treatment.

I consent to charge my credit card # _____ expiry date:_____
for missed appointments.
Patient signature:_____

I have read, understood, and agreed to the fees and payment obligations as listed above.

_____ _____
Patient (or parent/guardian) signature Date

Bridgeland Sport & Spine

Name: _____ Date: _____

Home Address:_____ Postal Code:_____

Home Telephone:_____ Business Telephone:_____

Date of Birth: _____/_____/_____ Age:_____ Sex: M/F E-Mail Address:_____
day/month/year

Medical Doctor: _____ Occupation: _____

1. Place a check mark if you suffer from any of the following

___diabetes ___migrains
___joint diseases ___tension headaches
___heart problems ___skin disease
___kidney disease ___digestive disease
___high blood pressure ___infectious disease
___respiratory disease ___joint or muscle injuries
___areas of numbness ___areas of chronic pain
___paralysis

List any other conditions not mentioned:_____

_____

_____

2. Are you taking medication? Y or N

If yes please list: _____ _____

_____ _____

_____ _____

3. Have you ever had local steroid injections to combat inflammation? Y or N

If yes please list: _____ _____

_____ _____

_____ _____

4. Do your muscles cramp easily or often? Y or N
Indicate which muscles in your body usually suffer from tension, soreness, etc.

___back ___neck ___shoulder
___arms ___chest ___legs
___wrists ___hips ___jaw

5. Which joints are often stiff and sore?_____

_____

_____

6. Are there any areas of your body you would feel uncomfortable having massaged?

   Specify:_____

7. Have you suffered from any accidents, trauma, or surgeries:_____

   _____

8. Previous treatment from other health care professionals.

   Please specify:_____

   Subjective improvements:_____

9. Please indicate your interest in the following benefits of massage:
   (1 indicates great interest, 5 little interest)

   Tension release 1 2 3 4 5
   Improvement of athletic performance 1 2 3 4 5
   Education on preventing muscle and joint problems 1 2 3 4 5
   Relaxing treatment 1 2 3 4 5
   Relief of pain or stiffness 1 2 3 4 5

10. Mark the areas of pain or unusual feelings. Use the appropriate symbols.

    "Circle" areas of PAIN
    "X" over the areas of JOINT AND MUSCLE STIFFNESS
    Draw "Squiggly Lines" on areas of NUMBNESS, TINGLING OR ALTERED SENSATIOMN

    Additional comments:_____

    _____