

INFORMED CONSENT

I hereby consent to my assessment and treatment under:

- Massage Therapy
- Matrix Repatterning
- Laser Therapy

I understand that all information about my health history and care is confidential and is required by my practitioner so that the most beneficial care may be provided. I agree to provide all required details of my health history and any changes to my health condition as may occur from time to time, including notifying my practitioner of major surgeries, implants, pacemakers, cancer or pregnancy. All such information will remain confidential unless I provide written consent to release it or is required by law.

I understand that any treatment or advice provided to me by my practitioner does not take the place of or exclude any other treatment or advice that I may be receiving now or in the future from a physician, surgeon or other licensed health care provider.

I understand that, as with all health care procedures, there are some risks to treatment. I may experience some temporary increase in symptoms, new sensations or fatigue over the first 24-48 hours following treatment. These effects are considered normal transient responses to treatment. I am encouraged to ask any questions and report any unusual symptoms which may be associated with any of my treatments.

For massage and laser therapy, I understand that my privacy will be assured as I have the right to undress only to my comfort level and as required for the treatment. Draping will be used except where treatment is required and as I choose to ensure my own comfort.

I am accepting this treatment of my own free will and am free to refuse any treatment or withdraw as a patient at any time. The ultimate responsibility for my health is my own. I understand that my practitioner has the right to discontinue providing services where it is apparent that my expectations or the services provided are not compatible with established standards or that my ongoing care requires referral to other health care professionals.

I am aware of the fee schedule and understand that fees are payable at the time of the appointment and that certain procedures may not be covered by my insurance provider. I acknowledge that I should provide 24 hours notice of any cancellation of an appointment and that I might otherwise be charged for any missed appointment or insufficient notice of a cancellation.

I confirm that I am legally authorized to grant consent to be treated as outlined above by the health care provider named below, on my own behalf or as legal guardian for the patient listed below.

Patient's name: _____

Legal guardian: _____

X Signature _____

Date: _____

Practitioner name: **Michel Boily, RMT, CMRP** _____

Confidential Health History Form

Date: _____

The information requested below will assist us in treating you safely. Feel free to ask any questions.

Name: _____ Date of birth: _____ Sex: F M

Address: _____ City _____ Postal code _____

Phone: Home _____ Mobile _____ Work _____ (ext. _____)

Email: _____ Occupation: _____ Referred by: _____

Main reason for seeking treatment: _____

Primary care physician /practitioner: _____ Phone: _____

Physician's address: _____

<p><u>✓ conditions you have or had:</u></p> <p>Cardiovascular:</p> <p><input type="checkbox"/> high blood pressure</p> <p><input type="checkbox"/> low blood pressure</p> <p><input type="checkbox"/> chronic congestive heart failure</p> <p><input type="checkbox"/> Heart attack</p> <p><input type="checkbox"/> phlebitis/ varicose veins</p> <p><input type="checkbox"/> stroke / CVA</p> <p><input type="checkbox"/> pacemaker or similar device</p> <p><input type="checkbox"/> other heart disease</p> <p>* Family history of any of above Y <input type="checkbox"/> N <input type="checkbox"/></p> <p>Respiratory:</p> <p><input type="checkbox"/> chronic cough</p> <p><input type="checkbox"/> shortness of breath</p> <p><input type="checkbox"/> bronchitis</p> <p><input type="checkbox"/> asthma</p> <p><input type="checkbox"/> emphysema</p> <p>* Family history of any of above Y <input type="checkbox"/> N <input type="checkbox"/></p>	<p>Infections:</p> <p><input type="checkbox"/> hepatitis</p> <p><input type="checkbox"/> skin conditions: _____</p> <p><input type="checkbox"/> Tuberculosis</p> <p><input type="checkbox"/> HIV / AIDS</p> <p><input type="checkbox"/> herpes</p> <p><input type="checkbox"/> other _____</p> <p>Other conditions:</p> <p><input type="checkbox"/> loss of sensation/ tingling</p> <p><input type="checkbox"/> sleeping problems</p> <p><input type="checkbox"/> diabetes</p> <p><input type="checkbox"/> allergies / hypersensitivities to what? _____</p> <p><input type="checkbox"/> cancer / of what? _____</p> <p><input type="checkbox"/> seizures</p> <p><input type="checkbox"/> arthritis</p> <p>* Family history of any of above Y <input type="checkbox"/> N <input type="checkbox"/></p>	<p>Head/neck:</p> <p><input type="checkbox"/> headaches <input type="checkbox"/> migraines</p> <p><input type="checkbox"/> vision problems _____</p> <p><input type="checkbox"/> sinus problems _____</p> <p><input type="checkbox"/> ear problems _____</p> <p><input type="checkbox"/> snoring/ sleep apnea</p> <p>Digestive system:</p> <p><input type="checkbox"/> heartburn / acid reflux</p> <p><input type="checkbox"/> constipation <input type="checkbox"/> diarrhea</p> <p><input type="checkbox"/> intestinal condition _____</p> <p>Women:</p> <p><input type="checkbox"/> pregnancy (due date: _____)</p> <p><input type="checkbox"/> breast sensitivity</p> <p><input type="checkbox"/> fibroids <input type="checkbox"/> cysts</p> <p><input type="checkbox"/> bladder infection <input type="checkbox"/> yeast infection</p> <p><input type="checkbox"/> painful menstruations</p> <p><input type="checkbox"/> painful intercourse</p>
---	---	---

Overall, how is your general health at this time? _____

Other comments _____

Any other medical condition? (i.e. haemophilia, osteoporosis, mental illness) No Yes

If yes, what? _____

Are you currently receiving treatment from another health care professional? No Yes (who? _____)

If yes, for what? _____

History of surgeries: (what?/dates)

Artificial joints, pins, plates, special implants? _____

Current medication: _____