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:

✓ conditions you have or had:

Cardiovascular:

☐ high blood pressure
☐ low blood pressure
☐ chronic congestive heart failure
☐ Heart attack
☐ phlebitis/ varicose veins
☐ stroke / CVA
☐ pacemaker or similar device
☐ other heart disease
* Family history of any of above Y ☐ N ☐

Respiratory:

☐ chronic cough
☐ shortness of breath
☐ bronchitis
☐ asthma
☐ emphysema
* Family history of any of above Y ☐ N ☐

Infections:

☐ hepatitis
☐ skin conditions: _____
☐ Tuberculosis
☐ HIV / AIDS
☐ herpes
☐ other _____

Other conditions:

☐ loss of sensation/ tingling
☐ sleeping problems
☐ diabetes
☐ allergies / hypersensitivities to what? _____
☐ cancer / of what? _____
☐ seizures
☐ arthritis
* Family history of any of above Y ☐ N ☐

Head/neck:

☐ headaches ☐ migraines
☐ vision problems _____
☐ sinus problems _____
☐ ear problems _____
☐ snoring/ sleep apnea

Digestive system:

☐ heartburn / acid reflux
☐ constipation ☐ diarrhea
☐ intestinal condition _____

Women:

☐ pregnancy (due date:_____)
☐ breast sensitivity
☐ fibroids ☐ cysts
☐ bladder infection ☐ yeast infection
☐ painful menstruations
☐ painful intercourse

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: _____