Woynarski Management Inc

GARRET WOYNARSKI
RMT, D.Ac.

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 Massage Therapist Association of Saskatchewan, Inc.

I hereby consent to 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 or 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 billing companies.

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.

Patient Name:_____ Signature of Patient/Guardian:_____

Witness:_____ Date Signed:_____

Garret Woynarski, RMT , D.Ac

Confidential Patient History Form for Massage Therapy and/or Acupuncture

Name:_____ Date of Birth (d/m/yr):_____

Address:_____ City: _____ Postal Code:_____

Phone # Home:_____ Work:_____ Cell:_____

Occupation:_____ Employer:_____ Hrs/wk:_____

Provincial Health #:_____ Email:_____

Did someone refer you to this office?_____

What are you seeking treatment for today? A)_____

B)_____

C)_____

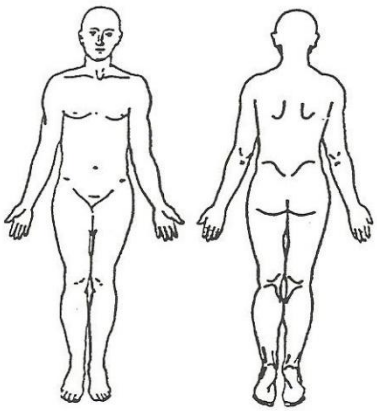
How long has this persisted?_____ What was the cause?_____

What professional treatments or home treatments have you used?_____

What are your goals and expectations with treatment today?_____

Please mark your pain level. (no pain) 0----1----2----3----4----5----6----7----8----9----10 (extreme pain)

Please diagram your problem areas.



List your vitamins, over-the-counter and prescription medications:

_____

Any accidents, traumas, surgeries, serious illnesses or broken bones as an adolescent, teen or adult?_____

Daily water consumption_____ Meals/day_____ Sleep hrs/night_____ Exercise/wk_____

Psychological and Emotional stress impacts physical healing. Feel free to list and discuss any immediate or future issues_____

Please check any of the following that apply to you:

Insomnia	☐	High/Low Blood Pressure	☐	Infectious/Contagious Conditions	☐
Trouble Falling Asleep	☐	Heartburn	☐	Metal/Artificial Joints or Plates	☐
Night Sweats	☐	Gas/Bloating	☐	Whiplash	☐
Excessive Dreaming	☐	Lactose Intolerance	☐	TMJ	☐
Fatigue	☐	Constipation	☐	Concussions	☐
Low Energy	☐	Nausea/Vomiting	☐	Dizziness	☐
Shortness of Breath	☐	Bowel Movement Irregularity	☐	Headaches	☐
Asthma	☐	Frequent Urination	☐	Ear Ringing	☐
Skin Conditions	☐	Painful Menstruation	☐	Arthritis	☐
Allergies (Food/Environmental)	☐	Irregular Periods	☐	Osteoporosis	☐
Heart Attack	☐	Absent Periods	☐	Lung Issues	☐
Stroke	☐	Painful Intercourse	☐	Intestinal Issues	☐
Cancer	☐	Miscarriage	☐	Stomach Issues	☐
HIV/AIDS	☐	Fertility Problems	☐	Spleen Issues	☐
Heart Palpitations	☐	Prostate Conditions	☐	Liver Issues	☐
Restlessness	☐	Erectile Dysfunction	☐	Bladder Issues	☐
Irritability	☐	Testicular Pain/Swelling	☐	Gall Bladder Issues	☐
Anxiety	☐	Incontinence	☐	Kidney Issues	☐
Stress	☐	Poor Circulation	☐	Heart Issues	☐
Depression	☐	Thyroid Problems	☐	Blood Disorder	☐

Please notify the Therapist if you are pregnant or have any other relevant digestive, respiratory, cardiovascular, immune or gynecological issues that may impact efficient assessment and treatment.

I attest the above information is true and accurate. I will notify the Therapist of any health changes in the future. I understand I will be billed for any missed appointments.

Signature:_____ Date:_____