Pure-Health
chiropractic | massage | shulman weightloss

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Dr. Laina Shulman, DC
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Massage Therapy Informed Consent:

Please read the following information thoroughly. If you have any questions, please do not hesitate to ask.

Clients Rights

- To determine what, if anything, may be done to your body: you exercise this right by giving or withholding your written informed consent.
- To refuse, modify, or terminate treatment (or any aspect of treatment) at any time regardless of prior consent.
- If any of the following areas (inner thigh, gluteal/buttox, abdomen, breast) are to be included in the treatment, the therapeutic indications and treatment procedures will be discussed by the client and therapist and additional consent will be given prior to undraping/treating these areas.
- All client information (verbal and written) is confidential and will be safeguarded by the therapist except when disclosure is required by law or an order of the court. Written authorization will be obtained prior to all communication concerning the client's records and all information provided to Pure-Health.
- Treatment will only be provided when there is reasonable expectation that it will be advantageous to the client.
- Draping defines a physical boundary, which ensures the safety, comfort and privacy of the client. Only those areas being treated will be undraped. Being fully draped or fully clothed during treatment is also an option.
- If the R.M.T. feels referral to another health care provider is necessary, this will be done with the clients consent.

Procedure (All of the following will be discussed and agreed upon by the client and the R.M.T.)

- Needs assessment and treatment plan including client health history form, assessment and examination procedures, treatment modalities, self-care and remedial exercise suggestions. Periodic review of all the above will be conducted.
- Disrobing and draping requirements and methods.
- Any potential risks, benefits, positive or adverse effects, alternatives to the proposed treatment plan.

Office Policies

By signing below I am stating that I have read the fee structure and agree to it. I also understand that these fees may change and if they do there will be advanced notice of anychanges.

*****24 hours** is required when **canceling an appointment. Failure** to do so will result in a **FULL PAYMENT fee.*****

Consent for personal information

I understand that Pure-Health will collect some personal information about me (e.g., health history, work phone number, home telephone number, address, email address). I understand that Pure-Health never shares any of this information without my consent. Pure-Health will use the personal information provided in order to contact me and send out newsletters etc. If I wish to stop receiving these contacts I will advise them.

I have read and fully understand all information included in this document and give my consent voluntarily.
Anything that was unclear was discussed and explained by the R.M.T.
I confirm that I am capable of consenting to the treatment.

SIGNATURE: _____ DATE: _____

PRINTED NAME: _____

NOTES MADE BY _____ RMT

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Massage Therapy Health History Form

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Name: _____ Date: _____

Address: _____ Postal Code: _____ Home Phone: _____

Work Phone: _____ Occupation: _____ Email _____

Birth Date: _____ Height _____ Weight _____ Referral Source: _____

Family Physician: _____ Physicians Address _____

Other Health Care: Chiropractor, Physiotherapist, Acupuncturist, Osteopath, Naturopath, Pedorthist, Other: _____

Over all Health: Excellent / Good / Fair / Poor

Emergency Contact: _____ Phone number: _____

Reason for seeking Massage Therapy: Relaxation: , Treatment: _____

Please indicate conditions you are experiencing, or have experienced in the past:

Cardiovascular System

- High Blood Pressure
- Low Blood Pressure
- Pacemaker
- Heart Disease
- Varicose Veins
- Poor Circulation
- Phlebitis
- Stroke
- Edema
- C.C.H.F

Nervous System

- Sciatica R / L
- Insomnia
- MS
- Parkinsons
- Seizures
- Paralysis
- Psychological issues

Respiratory System

- Asthma
- Bronchitis
- Breathing Difficulties
- TB
- Emphysema
- Chronic Cough
- Smoking

Immune System

- Allergies
- Hay fever
- Sinusitis
- Frequent Colds
- HIV/AIDS

Urinary Tract

- Kidney Stones
- Frequent Infections

Musculoskeletal:

- Arthritis OA or RA
- Bursitis
- Tendonitis
- Whiplash
- Tension Headaches
- Fractures
- Dislocations
- T.M.J
- Carpal Tunnel R / L
- Muscular Pain
- Muscular Weakness
- Muscle Joint Stiffness

Skin

- Rashes/Eruptions
- Sensitive
- Bruise Easy
- Eczema
- Herpes
- Cold Sores
- Contagious conditions

General

- Fatigue
- Dizziness
- Migraines
- Hepatitis
- Cancer
- Plates, Pins, Screws
- Vision/Hearing Impairment
- Left handed Right handed

Endocrine

- Thyroid Problems
- Diabetes

Surgery / Hospitalization (Date):

_____
_____
_____

Gastrointestinal

- Constipation
- Liver/Gallbladder
- Heartburn
- Ulcers
- Indigestion
- Nausea
- Frequent Vomiting
- Abdominal Pain
- Diverticulitis
- Colitis

Women

- PMS issues
- Menopause
- Endometriosis
- PID
- Fibroids, Cysts
- Mastectomy
- Pregnant
  - # of children_____

Other information (yes or no)

Previous Massage Experience **Y N**
Good Sleeping habits **Y N**
Hours per night _____
Regular Exercise **Y N**
Regular Eating Habits **Y N**

Hobbies, Recreation, Sports

_____
_____
_____

MOTOR VEHICLE ACCIDENT: Y N
Date _____

Current Meds and what they treat:

_____
_____
_____

Pure-Health Insurance Form

In order to ensure that we can answer all of your question please bring the following information to your first appointment.

What is your maximum coverage? _____

Are you the primary insured member? _____

Is there a maximum per adjustment (visit)? _____

Do you have a deductible? _____

What is your year end? _____

Do I need a prescription? If yes, from who?
_____

Are you covered by your spouse's insurance as well?
_____

Insurance provider:_____

Policy#: _____

Member#:_____

Spouse's name if spouse is the primary:_____

Thank you!