Massage Therapy Waiver and Consent Form

Massage Length*	Cost*
30 minutes	$70.00
45 minutes	$80.00
60 minutes	$95.00
90 minutes	$125.00

* For Hot Stones (Lomi Lomi), please inquire with the front staff and/or therapist

Forms of Payment:
We accept Interac, Visa, MasterCard, and cash. Any credit arrangements must be authorized in advance by the Massage Therapist.

We also offer direct billing for patients who have benefits from Alberta Blue Cross and Greenshield following a one-time $25 fee. Please check with your provider for specific coverage details.

Our office requires 24 hour notice for cancellation of Massage Therapy Appointments. Appointments missed or cancelled without sufficient notice will be charged half the cost of treatment.

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

Patient signature: _____

I understand that the massage I receive is provided for the basic purpose of relaxation, stress reduction, and relief of 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. I understand that the practice of Massage Therapy is a separate and distinct business entity than therapy from the practice of Chiropractic provided by Kinetic Performance Center's Chiropractors.

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.

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

Date_____

_____
Patient's Printed Name

_____
Patient's Signature

Kinetic Performance Center

Name: _____ Date: _____

Home Address: _____ Postal Code:_____

Home Telephone: _____ Cellular Telephone: _____

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

Medical Doctor: _____ Occupation: _____

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

___ Diabetes
___ Joint diseases
___ Heart problems
___ Kidney disease
___ High blood pressure
___ Respiratory disease
___ Areas of numbness
___ Paralysis
___ Migraines
___ Tension headaches
___ Skin disease
___ Digestive disease
___ Infectious disease
___ Joint or muscle injuries
___ Areas of chronic pain

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: _____

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

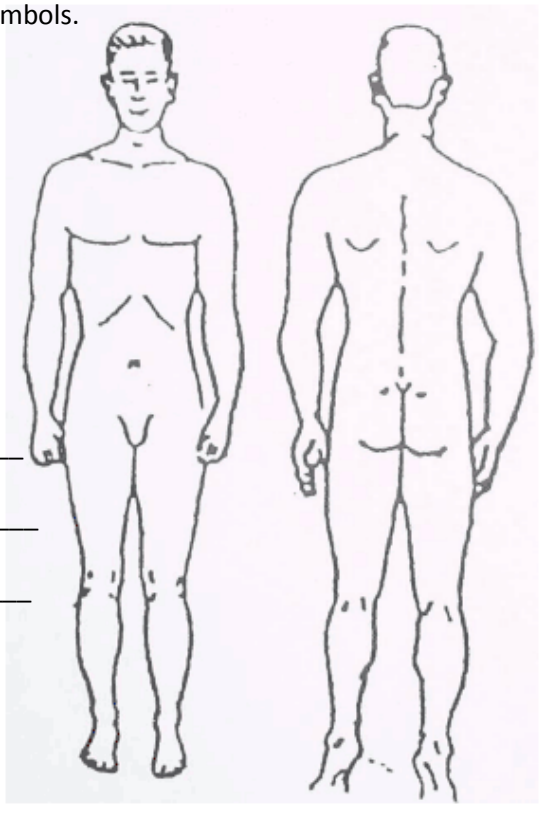
Tension release	1	2	3	4	5
Improvement of athletic performance	1	2	3	4	5
Education on preventing muscle and joint problems	1	2	3	4	5
Relaxing treatment	1	2	3	4	5
Relief of pain or stiffness	1	2	3	4	5

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 SENSATION



Additional comments: _____

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