Massage Therapy Intake & Consent Form

Name: _____ **Birth Date** _____

Address: _____ **Phone** : _____

Email Address:_____ **Home Phone**: _____

Emergency Contact: _____ **Relation:** _____

Phone #: _____ **Medical Doctor**: _____

Do you have an active ICBC claim? No/ Yes Claim Number: _____

How did you hear about us?_____

Health History

Please indicate any conditions you have experienced.
Indicate if it is a **C**URRENT condition or a **P**AST condition

C / P
- ❑❑Arthritis
- ❑❑Bursitis
- ❑❑Compression Syndrome
- ❑❑Degenerative Disc/Joint Disease
- ❑❑Dislocation/ Subluxation
- ❑❑Ligament/ Joint Sprain
- ❑❑ Muscle Strain/ Spasm
- ❑❑Postural Abnormality
- ❑❑Rods/Pins/Plates/Shunts
- ❑❑Implants
- ❑❑Spinal Injury/ Abnormality
- ❑❑Tendonitis
- ❑❑Headache/Migraine
- ❑❑Transplants
- ❑❑Other musculoskeletal

C/P
- ❑❑Contagious Skin Condition
- ❑❑Diabetes Type 1 / 2
- ❑❑Circulatory Conditions
- ❑❑Heart Conditions
- ❑❑Varicose Veins
- ❑❑High/Low Blood Pressure
- ❑❑Other cardiovascular
- ❑❑Lymphatic Conditions

- ❑❑Constipation
- ❑❑Diarrhea
- ❑❑IBS/Colitis
- ❑❑Incontinence
- ❑❑Kidney Disease
- ❑❑Urinary Tract Infection
- ❑❑Other Urinary Conditions
- ❑❑Pregnancy

C/P
- ❑❑Asthma
- ❑❑Bronchitis
- ❑❑Emphysema
- ❑❑Other Respiratory Conditions
- ❑❑Autoimmune Disease
- ❑❑Allergic reactions
- ❑❑Cancer
- ❑❑HIV / AIDS
- ❑❑Other Immune Conditions
- ❑❑Stomach Conditions
- ❑❑Ulcers
- ❑❑Hernia
- ❑❑Other Digestive Conditions

- ❑❑Dizziness/ Fainting
- ❑❑Epilepsy/ Other Seizures
- ❑❑Head Injury
- ❑❑Nausea
- ❑❑Spinal Cord Injury
- ❑❑ Other Neurological Condition:

List any hospitalizations, major accidents / illnesses / surgeries with dates:

_____

_____

WOMEN: List pregnancies/deliveries you've had (including dates) as well as any major complications associated with them: _____

LIFESTYLE

Please CIRCLE the answer closest to how you PRESENTLY feel (1 = POOR, 5 = EXCELLENT):

Quality of sleep 1 2 3 4 5 Hours of sleep per night? ____

Stress level 1 2 3 4 5

Exercise habits 1 2 3 4 5 Hours you exercise per week ____

List any medications or supplements you are taking and for what reason(s):

_____

_____

List any known allergies (including medications, foods, seasonal, oils/lotions, etc.):

_____

List activities and hobbies: _____

Occupation: _____

MAIN HEALTH CONCERNS

PRIMARY COMPLAINT: _____

Pain level: (none) 0 1 2 3 4 5 6 7 8 9 10 (worst imaginable)

Symptoms:_____

_____

_____

How Long has this been Occurring_____

How did it begin? _____

What aggravates it? _____

What relieves it? _____

Have you had treatments for this complaint by any other Therapist, Practitioner or Specialist?

_____

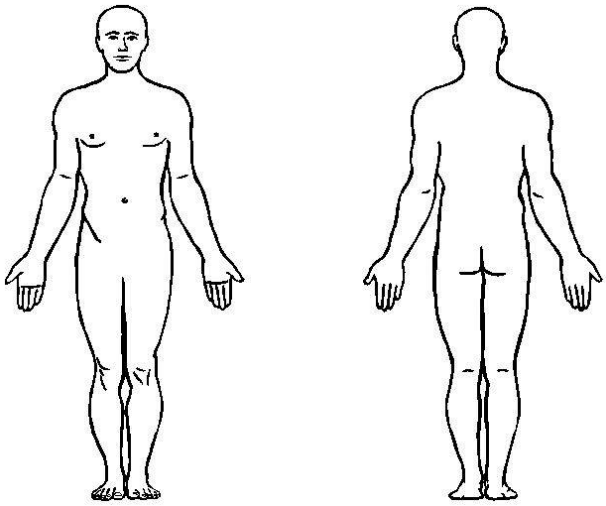
Was it effective?___

Is your condition affecting your ability to work or otherwise be active? ❑No ❑Yes

❑Some physical restrictions ❑Need some assistance ❑Need assistance often ❑Can't care for self

Show in the diagram the nature of your symptoms using the symbols indicated below:

Aching ○	Burning #	Numbness ≈
Tingling ∧	Stabbing X	Shooting →



List complimentary health care you have participated in:

	When	Reason For care		When	Reason For care
Massage Therapy	_____	_____	Physiotherapy	_____	_____
Chiropractic	_____	_____	Naturopathic	_____	_____
Acupuncture	_____	_____	Other	_____	_____

Is there anything else about you or your health that we should know?

_____

_____

AUTOMATED APPOINTMENT REMINDERS

After making an appointment booking and have given your email, you will receive an email confirmation of your booking. You will also receive an email reminder 48 hrs before your scheduled appointment. Please know that confirmation emails and reminders are sent only as a courtesy, it is the clients responsibility to record the date and time of their appointments**.**please make note of your appointment. If you have opted out of the email/text option, please make a note of your appointment. PLEASE INITIAL HERE:_____

CANCELLATION / MISSED APPOINTMENT POLICY

Please understand that it is your responsibility to show up and on time for your appointment. If you show up late, we will have to shorten your appointment time accordingly in order to be prompt and prepared for upcoming patients. If you need to reschedule your appointment, please give us at least 24 **HOURS NOTICE** so that we can attempt to fill the appointment . Should an appointment be cancelled with less than 24 hours notice, 100% of your scheduled appointment fee will apply. If you miss your appointment 100% of the appointment fee will apply. Please understand that this policy is in place as we do our best to respect all of our clients time and ask the same in return. PLEASE INITIAL HERE TO CONFIRM YOU HAVE READ AND UNDERSTOOD THE ABOVE: _____

CONSENT FOR TREATMENT Registered Massage Therapists (RMTs) are health care professionals committed to restoring and maintaining optimal health. They are educated and trained to accurately assess and treat using techniques that include Swedish massage, joint mobilization, hydrotherapy, and rehabilitative exercise such as stretching, strengthening, postural exercise and patient education.

I hereby state that the information that I have give is true and accurate to the best of my knowledge. I understand that a record will be kept of the health services provided to me at this clinic. This record, along with my personal information, will be kept confidential and will not be released to others unless so directed by myself or unless law requires it. I understand that I may look at my medical record at anytime and can request a copy of it by paying the appropriate fee. I understand that information from my medical record may be analyzed for research purposes and that my identity will be protected and kept confidential. I also understand that I am expected to notify my RMT if there are any changes to my health or medications/drugs I am taking OR if I am uncomfortable with ANY part of my massage therapy treatments. I understand that results are not guaranteed. I do not expect that the RMT will be able to anticipate and explain all risks and complications. With this knowledge, I voluntarily consent to the therapeutic procedures mentioned above. I intend this consent form to cover the entire course of treatment with the Massage Therapist I have booked appointments with. I understand that I am free to withdraw my consent and to discontinue participation in these procedures at any time.

Patient Name: _____

Guardian Name (if patient is under 19 yrs): _____

Signature of Patient (or Guardian): _____

Date: _____

Created by Kimberley Matthias.RMT