

Massage Therapy Intake & Consent Form

ABOUT YOU

Name: _____ Birth Date (DD/MM/YYYY) _____ / _____ / _____ Age: _____

Address: _____ City: _____ Province: _____ Postal: _____

We use an automated email & text message system for appointment reminders (see details on last page) – please provide us with your contact info below and indicate (by checking the box & initialing) if you would like to receive these notifications.

E-mail address: _____

_____ (initial) subscribe me to email appointment reminders & notifications _____ (initial) subscribe me to newsletter & promotional emails

Mobile Phone #: _____ _____ (initial) subscribe me to text message appointment reminders

Home Phone #: _____ Work Phone #: _____ x _____

How did you hear about Calm Massage Therapy & Wellness Studio? Friend –(who?) _____

Internet Rack card/Business Card Mail-out Doctor Walk/Drive By Other _____

Emergency Contact: _____ Relation: _____ Phone #: _____

Regular Medical Doctor: _____

Care Card # _____ Do you have extended medical coverage? No Yes

Do you have an active ICBC claim? No Yes (please inform us as you will need to fill out the related form)

HEALTH HISTORY

Please indicate any conditions you have experienced. Indicate if it is a CURRENT condition (darken first box) or a PAST condition (darken second box):

- | | | |
|---|---|--|
| <p>C / P</p> <p><input type="checkbox"/> <input type="checkbox"/> Arthritis</p> <p><input type="checkbox"/> <input type="checkbox"/> Bursitis</p> <p><input type="checkbox"/> <input type="checkbox"/> Compression Syndrome</p> <p><input type="checkbox"/> <input type="checkbox"/> Contusion</p> <p><input type="checkbox"/> <input type="checkbox"/> Degenerative Disc/Joint Disease</p> <p><input type="checkbox"/> <input type="checkbox"/> Dislocation/ Subluxation</p> <p><input type="checkbox"/> <input type="checkbox"/> Implants</p> <p><input type="checkbox"/> <input type="checkbox"/> Ligament/ Joint Sprain</p> <p><input type="checkbox"/> <input type="checkbox"/> Muscle Strain/ Spasm</p> <p><input type="checkbox"/> <input type="checkbox"/> Postural Abnormality</p> <p><input type="checkbox"/> <input type="checkbox"/> Rods/Pins/Plates/Shunts</p> <p><input type="checkbox"/> <input type="checkbox"/> Spinal Injury/ Abnormality</p> <p><input type="checkbox"/> <input type="checkbox"/> Tendonitis</p> <p><input type="checkbox"/> <input type="checkbox"/> Tension Headache</p> <p><input type="checkbox"/> <input type="checkbox"/> Transplants</p> <p><input type="checkbox"/> <input type="checkbox"/> Other Musculoskeletal Condition: _____</p> <p><input type="checkbox"/> <input type="checkbox"/> Corrective Lenses/ Contacts</p> <p><input type="checkbox"/> <input type="checkbox"/> Dizziness/ Fainting</p> <p><input type="checkbox"/> <input type="checkbox"/> Epilepsy/ Other Seizures</p> <p><input type="checkbox"/> <input type="checkbox"/> Head Injury</p> <p><input type="checkbox"/> <input type="checkbox"/> Headaches/ Migraines</p> <p><input type="checkbox"/> <input type="checkbox"/> Nausea</p> <p><input type="checkbox"/> <input type="checkbox"/> Spinal Cord Injury</p> <p><input type="checkbox"/> <input type="checkbox"/> Other Neurological Condition: _____</p> | <p>C / P</p> <p><input type="checkbox"/> <input type="checkbox"/> Contagious Skin Condition</p> <p><input type="checkbox"/> <input type="checkbox"/> Eczema</p> <p><input type="checkbox"/> <input type="checkbox"/> Serious Burn</p> <p><input type="checkbox"/> <input type="checkbox"/> Pressure Ulcer</p> <p><input type="checkbox"/> <input type="checkbox"/> Psoriasis</p> <p><input type="checkbox"/> <input type="checkbox"/> Other Skin Condition _____</p> <p><input type="checkbox"/> <input type="checkbox"/> Diabetes Type 1/2</p> <p><input type="checkbox"/> <input type="checkbox"/> Hypo/ Hyperthyroidism</p> <p><input type="checkbox"/> <input type="checkbox"/> Other Hormonal Condition: _____</p> <p><input type="checkbox"/> <input type="checkbox"/> Circulatory Problem</p> <p><input type="checkbox"/> <input type="checkbox"/> Heart Condition</p> <p><input type="checkbox"/> <input type="checkbox"/> High/ Low Blood Pressure</p> <p><input type="checkbox"/> <input type="checkbox"/> Varicose Veins</p> <p><input type="checkbox"/> <input type="checkbox"/> Other Cardiovascular Condition: _____</p> <p><input type="checkbox"/> <input type="checkbox"/> Constipation</p> <p><input type="checkbox"/> <input type="checkbox"/> Diarrhea</p> <p><input type="checkbox"/> <input type="checkbox"/> Irritable Bowel / Colitis</p> <p><input type="checkbox"/> <input type="checkbox"/> Stomach Condition</p> <p><input type="checkbox"/> <input type="checkbox"/> Ulcer</p> <p><input type="checkbox"/> <input type="checkbox"/> Hernia</p> <p><input type="checkbox"/> <input type="checkbox"/> Other Digestive Condition: _____</p> | <p>C / P</p> <p><input type="checkbox"/> <input type="checkbox"/> Asthma</p> <p><input type="checkbox"/> <input type="checkbox"/> Bronchitis</p> <p><input type="checkbox"/> <input type="checkbox"/> Emphysema</p> <p><input type="checkbox"/> <input type="checkbox"/> Sinusitis</p> <p><input type="checkbox"/> <input type="checkbox"/> Other Respiratory Condition _____</p> <p><input type="checkbox"/> <input type="checkbox"/> Allergic Reactions</p> <p><input type="checkbox"/> <input type="checkbox"/> Autoimmune Disease</p> <p><input type="checkbox"/> <input type="checkbox"/> Cancer</p> <p><input type="checkbox"/> <input type="checkbox"/> Current Cold/Virus</p> <p><input type="checkbox"/> <input type="checkbox"/> HIV</p> <p><input type="checkbox"/> <input type="checkbox"/> Other Lymph/Immune Condition: _____</p> <p><input type="checkbox"/> <input type="checkbox"/> Incontinence</p> <p><input type="checkbox"/> <input type="checkbox"/> Kidney Disease</p> <p><input type="checkbox"/> <input type="checkbox"/> Urinary Tract Infections</p> <p><input type="checkbox"/> <input type="checkbox"/> Other Urinary Condition: _____</p> <p>Other Health Conditions:</p> <p><input type="checkbox"/> <input type="checkbox"/> _____</p> <p><input type="checkbox"/> <input type="checkbox"/> _____</p> <p><input type="checkbox"/> <input type="checkbox"/> _____</p> <p><input type="checkbox"/> <input type="checkbox"/> _____</p> <p><input type="checkbox"/> <input type="checkbox"/> _____</p> |
|---|---|--|

List any medical conditions that run in your family: _____

List any hospitalizations, major accidents / illnesses / surgeries (include approximate DATES): _____

List any previous complimentary health care you have participated in:

	LAST VISIT DATE	REASON FOR CARE	TREATMENT ONGOING
<input type="checkbox"/> Massage Therapy	_____	_____	<input type="checkbox"/>
<input type="checkbox"/> Chiropractic Care	_____	_____	<input type="checkbox"/>
<input type="checkbox"/> Physiotherapy	_____	_____	<input type="checkbox"/>
<input type="checkbox"/> Acupuncture	_____	_____	<input type="checkbox"/>
<input type="checkbox"/> Naturopathic Care	_____	_____	<input type="checkbox"/>
<input type="checkbox"/> Other _____	_____	_____	<input type="checkbox"/>

WOMEN: List the number of 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?	_____
Energy level	1	2	3	4	5		
Eating habits	1	2	3	4	5	Number of meals you regularly eat per day	_____
Stress level	1	2	3	4	5		
Exercise habits	1	2	3	4	5	Hours you exercise per week	_____
Fluid intake	1	2	3	4	5		

- Do you smoke cigarettes? No Yes, occasionally Yes, regularly
- Do you drink alcohol? No Yes, occasionally Yes, regularly
- Do you drink caffeine? No Yes, occasionally Yes, regularly

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

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

List any activities, sports, hobbies (jogging, soccer, crafts, computer, etc.): _____

Occupation: _____ How much per week do you work on average? _____ hours

How do you spend most of your days?

- Sitting
- Standing
- Light manual labour
- Manual labour
- Hard manual labour

MAIN HEALTH CONCERNS

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

Symptoms: _____

How long have you had this? _____

How did it begin? _____

What aggravates it? _____

What relieves it? _____

What other healthcare practitioners have you seen about this? _____

Type of care given? _____ Was it effective? _____

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

Symptoms: _____

How long have you had this? _____

How did it begin? _____

What aggravates it? _____

What relieves it? _____

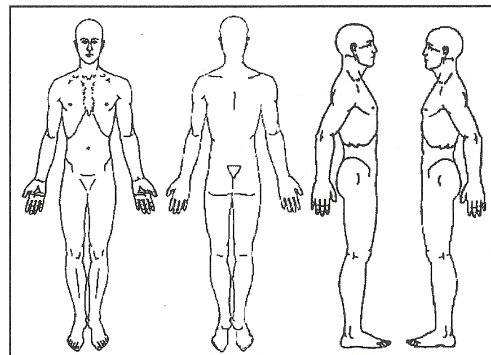
What other healthcare practitioners have you seen about this? _____

Type of care given? _____ Was it effective? _____

- Are your complaints affecting your ability to work or otherwise be active? No effect Yes
- Some physical restrictions Need limited assistance Need assistance often Can't care for self

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

Aching ○ Burning # Numbness ≈
 Tingling ^ Stabbing × Shooting →



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

FEE SCHEDULE

The fee schedule below applies to all persons paying privately. If you have extended medical coverage, please check your particular policy to see how much you will be reimbursed—plans vary between individuals. If you are covered under ICBC please see related forms for a fee schedule. For Premium Assistance patients, Medical Services Plan will reimburse you \$23 per treatment for up to 10 visits per calendar year. Please ask us for the form for you to send in. Payment for all treatment whether private or insured is ultimately the responsibility of the patient. We accept cash, debit, visa and mastercard for payment. GST applies to all fees listed below and these fees are subject to change without notice.

Fees for massage therapy treatments:

	<u>Initial Visit</u>	<u>Subsequent Visits</u>	
Thirty minutes	\$75.00	\$55.00	
Forty-five minutes	\$95.00	\$75.00	<u>Add-on Treatments</u>
Sixty minutes	\$115.00	\$95.00	Paraffin Therapy \$10
Seventy-five minutes	\$135.00	\$115.00	Stone Therapy \$20
Ninety minutes	\$155.00	\$135.00	(not if pregnant)

AUTOMATED APPOINTMENT REMINDERS

If you have indicated participation in this, two days before your scheduled appointment you will receive an ‘Appointment Reminder/Confirmation’ email asking you to click the link to confirm that you will be at your appointment. If you do not confirm via email, then one day prior to the appointment you will receive a **text message** requesting that you reply ‘C’ to confirm that you will be at your appointment. (If you do not have a texting plan with your service provider, message and data rates may apply. You can unsubscribe to the text message by replying “STOP”.)

CANCELLATION / MISSED APPOINTMENT POLICY

Please understand that it is ultimately YOUR responsibility to be punctual for your visit. 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 fill the space. Should an appointment be cancelled with less than 24 hours notice, 50% of your scheduled appointment fee will apply. Should an appointment be missed entirely without any notice, the full appointment fee will apply. Please understand that this policy is in place because we do our best to respect you and your time and we expect the same from you in return. THANK YOU!

TO CONFIRM THAT YOU HAVE READ THE ABOVE AND ARE AWARE OF THE FEES THAT APPLY FOR LATE CANCELLATIONS AND MISSED APPOINTMENTS, **PLEASE INITIAL HERE:** _____

CONSENT FOR TREATMENT

Registered Massage Therapists (RMTs) are health care professionals committed to restoring and maintaining optimal health and pain-free function of the body. They are educated and trained to accurately assess and treat with techniques that include massage and manual therapy, joint mobilization, hydrotherapy, and rehabilitative exercise such as stretching, strengthening, postural exercise and patient education.

I hereby state that the above information that I have filled in is true and accurate to the best of my knowledge. I authorize Calm Massage Therapy & Wellness Studio and its associated RMTs to communicate with my Medical Doctor as deemed necessary for my treatment. 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 this Massage Therapist. I understand that I am free to withdraw my consent and to discontinue participation in these procedures at any time. I understand that I will be receiving massage therapy as an adjunctive form of healthcare, and that I must continue to receive appropriate medical care from my Medical Doctor.

Patient Name: _____ Guardian Name (if patient is a child): _____

Signature of Patient (or Guardian): _____ Date: _____