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):

C / P
☐ ☐ Arthritis
☐ ☐ Bursitis
☐ ☐ Compression Syndrome
☐ ☐ Contusion
☐ ☐ Degenerative Disc/Joint Disease
☐ ☐ Dislocation/ Subluxation
☐ ☐ Implants
☐ ☐ Ligament/ Joint Sprain
☐ ☐ Muscle Strain/ Spasm
☐ ☐ Postural Abnormality
☐ ☐ Rods/Pins/Plates/Shunts

☐ ☐ Spinal Injury/ Abnormality
☐ ☐ Tendonitis
☐ ☐ Tension Headache
☐ ☐ Transplants
☐ ☐ Other Musculoskeletal Condition:
____

☐ ☐ Corrective Lenses/ Contacts
☐ ☐ Dizziness/ Fainting
☐ ☐ Epilepsy/ Other Seizures
☐ ☐ Head Injury
☐ ☐ Headaches/ Migraines
☐ ☐ Nausea
☐ ☐ Spinal Cord Injury
☐ ☐ Other Neurological Condition:
____

C / P
☐ ☐ Contagious Skin Condition
☐ ☐ Eczema
☐ ☐ Serious Burn
☐ ☐ Pressure Ulcer
☐ ☐ Psoriasis
☐ ☐ Other Skin Condition
____

☐ ☐ Diabetes Type 1/2
☐ ☐ Hypo/ Hyperthyroidism
☐ ☐ Other Hormonal Condition:
____

☐ ☐ Circulatory Problem
☐ ☐ Heart Condition
☐ ☐ High/ Low Blood Pressure
☐ ☐ Varicose Veins
☐ ☐ Other Cardiovascular Condition:
____

☐ ☐ Constipation
☐ ☐ Diarrhea
☐ ☐ Irritable Bowel / Colitis
☐ ☐ Stomach Condition
☐ ☐ Ulcer
☐ ☐ Hernia
☐ ☐ Other Digestive Condition:
____

C / P
☐ ☐ Asthma
☐ ☐ Bronchitis
☐ ☐ Emphysema
☐ ☐ Sinusitis
☐ ☐ Other Respiratory Condition
____

☐ ☐ Allergic Reactions
☐ ☐ Autoimmune Disease
☐ ☐ Cancer
☐ ☐ Current Cold/Virus
☐ ☐ HIV
☐ ☐ Other Lymph/Immune Condition:
____

☐ ☐ Incontinence
☐ ☐ Kidney Disease
☐ ☐ Urinary Tract Infections
☐ ☐ Other Urinary Condition:
____

Other Health Conditions:
☐ ☐ ___________________________
☐ ☐ ___________________________
☐ ☐ ___________________________
☐ ☐ ___________________________
☐ ☐ ___________________________
☐ ☐ ___________________________

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
☐ Massage Therapy	______________	____	☐
☐ Chiropractic Care	______________	____	☐
☐ Physiotherapy	______________	____	☐
☐ Acupuncture	______________	____	☐
☐ Naturopathic Care	______________	____	☐
☐ Other ____________	______________	____	☐

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? ____

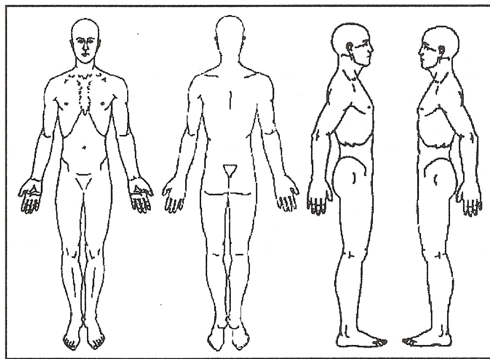
Type of care given? ____ Was it effective? ______________________

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 Λ	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:

Twenty minutes *	$40.00
Thirty minutes *	$60.00
Forty-five minutes	$80.00
Sixty minutes	$100.00
Seventy-five minutes	$120.00
Ninety minutes	$140.00

Add-on Treatments	
Paraffin Therapy	$10
Stone Therapy (not if pregnant)	$20

**20 and 30 minute length bookings are not accepted for first time visitors as we need more time for a thorough initial assessment.*

Youth (12 – 18 yrs) rates are $10 off the above. Children (up to 12 yrs) are 25 minutes for $35 and 40 minutes for $55 (also plus gst).

PACIFIC BLUE CROSS DIRECT BILLING

If you want us to direct bill for you with Pacific Blue Cross please complete our Assignment and Disclosure Form. After completing the form, you can email it to us at: Reception@be-calm.ca (your signature will be required on your next visit) OR print it and bring it with you to your next appointment. Please note that we cannot bill BlueCross for missed or late cancelled appointments and will require private payment for those fees if incurred.

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: ____________________________