Maternity 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 ☐ MD/ Midwife ☐ Walk/Drive By ☐ Other _____

Emergency Contact: _____ Relation: _____ Phone #: _____

Regular Medical Doctor: _____ ☐ Also for maternity care

Maternity Healthcare Provider: _____ ☐ Doctor ☐ Midwife

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)

PLEASE FILL IN WHAT APPLIES TO YOU

☐ I'm trying to conceive

I have tried the following natural/medical fertility treatments/procedures (fertility drugs, surgery, in vitro fertilization, etc)

_____

_____

☐ I'm pregnant

☐ This is my first pregnancy I'm carrying ☐ one ☐ twins ☐ more: _____

I'm due: _____ I'm _____ weeks Starting mat leave: _____ (approx date)

☐ I have birthed one or more babies in the past

	Youngest	<———————————————————————>				Oldest
Birth date:	_____	_____	_____	_____	_____	_____
Child's age:	_____	_____	_____	_____	_____	_____
Cesarean birth	☐	☐	☐	☐	☐	☐
< 38 wks gestation	☐	☐	☐	☐	☐	☐
Birth was induced	☐	☐	☐	☐	☐	☐

CURRENT &/OR PAST PREGNANCIES

Please indicate any pregnancy complications that you have experienced (miscarriage, ectopic pregnancy, premature labour, (pre)eclampsia, gestational diabetes, etc):_____

_____

_____

Please indicate any PREGNANCY RELATED conditions you have experienced either in this CURRENT pregnancy (darken first box) or in any PAST pregnancies (darken second box):

C / P	C / P	C / P	C / P
☐ ☐ Muscle cramps	☐ ☐ Varicose veins	☐ ☐ Vulvar varicosities`	☐ ☐ Groin pain
☐ ☐ Headaches	☐ ☐ Sinus concerns	☐ ☐ Hemorrhoids	☐ ☐ Hip pain
☐ ☐ Carpal tunnel pain	☐ ☐ Anxiety/ Depression	☐ ☐ Neck pain	☐ ☐ Thigh/leg pain
☐ ☐ Sciatica	☐ ☐ Fatigue	☐ ☐ Upper back pain	☐ ☐ Foot pain
☐ ☐ Constipation/Gas	☐ ☐ Nausea	☐ ☐ Mid back pain	☐ ☐ Rib/thorax pain
☐ ☐ Restricted breathing	☐ ☐ Stress	☐ ☐ Low back pain	☐ ☐ Shoulder pain
☐ ☐ Swelling (edema)	☐ ☐ High/low blood pressure	☐ ☐ Pelvic pain	☐ ☐ Arm/hand pain

HEALTH HISTORY

Please indicate any NON PREGNANCY RELATED 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 _____	_____	_____	☐

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

Is there anything else about you or your health (pregnancy related or not) 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. At the clinic, we accept cash, debit, visa and mastercard for payment. For home visits we only accept cash or cheque (NSF fees apply). GST applies to all fees listed below and these fees are subject to change without notice.

Fees for massage therapy treatments:

	Initial Visit	Subsequent Visits
Thirty minutes	$75.00	$55.00
Forty-five minutes	$95.00	$75.00
Sixty minutes	$115.00	$95.00
Seventy-five minutes	$135.00	$115.00
Ninety minutes	$155.00	$135.00

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

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/ Maternity Healthcare Provider 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/ Maternity Healthcare Provider.

Patient Signature: _____ Print Name: _____Date: _____