

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	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
< 38 wks gestation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Birth was induced	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

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
<input type="checkbox"/> <input type="checkbox"/> Muscle cramps	<input type="checkbox"/> <input type="checkbox"/> Varicose veins	<input type="checkbox"/> <input type="checkbox"/> Vulvar varicosities*	<input type="checkbox"/> <input type="checkbox"/> Groin pain
<input type="checkbox"/> <input type="checkbox"/> Headaches	<input type="checkbox"/> <input type="checkbox"/> Sinus concerns	<input type="checkbox"/> <input type="checkbox"/> Hemorrhoids	<input type="checkbox"/> <input type="checkbox"/> Hip pain
<input type="checkbox"/> <input type="checkbox"/> Carpal tunnel pain	<input type="checkbox"/> <input type="checkbox"/> Anxiety/ Depression	<input type="checkbox"/> <input type="checkbox"/> Neck pain	<input type="checkbox"/> <input type="checkbox"/> Thigh/leg pain
<input type="checkbox"/> <input type="checkbox"/> Sciatica	<input type="checkbox"/> <input type="checkbox"/> Fatigue	<input type="checkbox"/> <input type="checkbox"/> Upper back pain	<input type="checkbox"/> <input type="checkbox"/> Foot pain
<input type="checkbox"/> <input type="checkbox"/> Constipation/Gas	<input type="checkbox"/> <input type="checkbox"/> Nausea	<input type="checkbox"/> <input type="checkbox"/> Mid back pain	<input type="checkbox"/> <input type="checkbox"/> Rib/thorax pain
<input type="checkbox"/> <input type="checkbox"/> Restricted breathing	<input type="checkbox"/> <input type="checkbox"/> Stress	<input type="checkbox"/> <input type="checkbox"/> Low back pain	<input type="checkbox"/> <input type="checkbox"/> Shoulder pain
<input type="checkbox"/> <input type="checkbox"/> Swelling (edema)	<input type="checkbox"/> <input type="checkbox"/> High/low blood pressure	<input type="checkbox"/> <input type="checkbox"/> Pelvic pain	<input type="checkbox"/> <input type="checkbox"/> 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
<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"/>

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:

Twenty minutes *	\$40.00	<u>Add-on Treatments</u>
Thirty minutes *	\$60.00	Paraffin Therapy \$10
Forty-five minutes	\$80.00	Stone Therapy \$20
Sixty minutes	\$100.00	(not if pregnant)
Seventy-five minutes	\$120.00	
Ninety minutes	\$140.00	

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

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/ 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: _____