Massage Therapy Intake & Consent Form

ABOUT YOU

Name: ____ Birth Date (DD/MM/YYYY) _______ /_____ /______ Age: __________

Address: ____ City: ________________ Province: _____ Postal: ___________

Home Phone #: _______________________ Work Phone #: _______________x_____

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. (You can receive emails, OR text, OR both email and text simultaneously)

	appointment reminders & notifications	newsletter & promotional messages
E-mail address: ________________________________	☐ ___ (initial)	☐ ___ (initial)
Mobile Phone #: _______________________________	☐ ___ (initial)	☐ ___ (initial)

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? ____________________

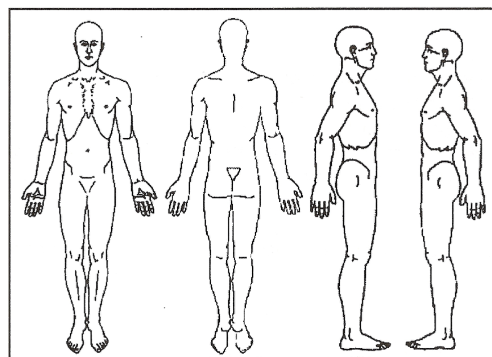
Are your complaints affecting your ability to work or otherwise be active? ☐ No effect ☐ Yes

☐ 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.

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	$20
(not if pregnant)	

**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).

DIRECT BILLING TO INSURANCE PROVIDERS

If you want us to direct bill for you please complete our *Assignment and Disclosure Form* - form will download to your computer (check your Downloads folder. 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 direct bill for missed or late cancelled appointments and will require private payment for those fees if incurred.

AUTOMATED REMINDERS, CANCELLATION / MISSED APPOINTMENT POLICY

Our scheduling system, MindBody, has a feature that allows us to send automated appointment reminders – occasionally technology has glitches so we cannot guarantee that you will receive these reminders. This is how the system is supposed to work if you are "opted in"…

TWO days before a scheduled appointment you will receive an email requesting confirmation that you will attend your visit. If you are opted in to receive text appointment reminders and did not click that confirmation link from the email, then ONE day before a scheduled appointment you will receive a text requesting confirmation that you will attend your visit. If you cannot attend your booking **you need to call or email your RMT** ASAP so that we can try to fill the space or fees may apply. (A non-response to the automated confirmation request does not constitute proper notice of cancellation.)

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!

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: _____________________________