

Maternity 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: _____	<input type="checkbox"/> _____ (initial)	<input type="checkbox"/> _____ (initial)
Mobile Phone #: _____	<input type="checkbox"/> _____ (initial)	<input type="checkbox"/> _____ (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)

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

- C / P
Contagious Skin Condition
Eczema
Serious Burn
Pressure Ulcer
Psoriasis
Other Skin Condition
Diabetes Type 1/2
Hypo/ Hyperthyroidism
Other Hormonal Condition:

- C / P
Asthma
Bronchitis
Emphysema
Sinusitis
Other Respiratory Condition
Allergic Reactions
Autoimmune Disease
Cancer
Current Cold/Virus
HIV
Other Lymph/Immune Condition:

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

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

- Incontinence
Kidney Disease
Urinary Tract Infections
Other Urinary Condition:

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

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

Table with columns: Treatment Type, Last Visit Date, Reason for Care, Treatment Ongoing. Rows include Massage Therapy, Chiropractic Care, Physiotherapy, Acupuncture, Naturopathic Care, and Other.

LIFESTYLE

Please CIRCLE the answer closest to how you PRESENTLY feel (1 = POOR, 5 = EXCELLENT):

- Quality of sleep (1-5)
Energy level (1-5)
Eating habits (1-5)
Stress level (1-5)
Exercise habits (1-5)
Fluid intake (1-5)
Hours of sleep per night?
Number of meals you regularly eat per day
Hours you exercise per week

- 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. 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	<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.*

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 Signature: _____ Print Name: _____ Date: _____