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)**yes** to email appointment reminders & notifications

Mobile Phone #: _____

❑___ (initial)**yes** text appointment reminders & notifications

Home Phone #: _____ **Work Phone** #: _____x_____

How did you hear about Fort Langley Massage Therapy & HolisticHealth)_____

Emergency Contact: _____**Relation:** _____

Phone #: _____ **Regular Medical Doctor**: _____

Do you have an active ICBC claim? No/ Yes

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
_____
❑❑Dizziness/ Fainting
❑❑Epilepsy/ Other Seizures
❑❑Head Injury
❑❑ Headaches/ Migraines
❑❑Nausea
❑❑Spinal Cord Injury
❑❑ Other Neurological Condition:
_____

C/P
❑❑Contageous Skin Condition
❑❑Serious burns
❑❑Other skin Conditions
❑❑Skin Ulcers
_____

❑❑Diabetes Tpe 1 / 2
❑❑Circulatory Conditions
❑❑Heart Conditions
❑❑High/Low Blood Pressure
❑❑Varicos Veins
❑❑Other Cardiovascular
_____
❑❑Pregnancy
❑❑Stomach Conditions
❑❑Ulcers
❑❑Hernia
❑❑Other Digestive Conditions
_____

C/P
❑❑Asthma
❑❑Bronchitis
❑❑Emphysema
❑❑Other Respiratory Conditions
_____

❑❑Allergic reactions
❑❑Autoimmune Disease
❑❑Cancer
❑❑HIV
❑❑Lymphatic Conditions
❑❑Other Immune Conditions
_____
❑❑Constipation
❑❑Diarrhea
❑❑IBS/Colitis
❑❑Incontinence
❑❑Kidney Disease
❑❑Urinary Tract Infection
❑❑Other Urinary Conditions
_____

List any hospitalizations, major accidents / illnesses / surgeries (include approximate DATES):

_____

_____

_____

List any previous complimentary health care you have participated in:

	How Long ago	Reason For care	Ongoing
❑Massage Therapy	_____	_____	❑
❑Physiotherapy	_____	_____	❑
❑Chiropractic Care	_____	_____	❑
❑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? ____

Stress level 1 2 3 4 5

Exercise habits 1 2 3 4 5 Hours you exercise per week ____

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: _____

MAIN HEALTH CONCERNS

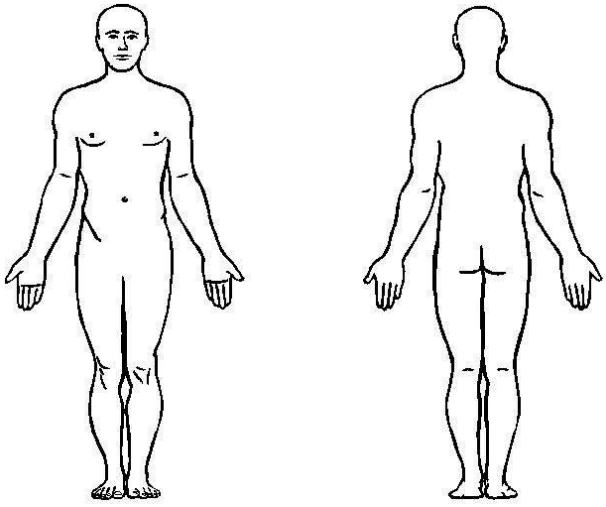
PRIMARY COMPLAINT: _____ Pain level: (none) 0 1 2 3 4 5 6 7 8 9 10 (worst imaginable)
Symptoms:_____
_____
_____
How Long has this been Occurring_____
How did it begin? _____
What aggravates it? _____
What relieves it? _____
What other healthcare practitioners have you seen about this? _____
Type of care given? _____ Was it effective? Y/N Somewhat

OTHER COMPLAINTS: _____ Pain level: (none) 0 1 2 3 4 5 6 7 8 9 10 (worst imaginable)
Symptoms:
_____
_____
How long has this been occurring? _____
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? Y/N Somewhat

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 in the diagram the nature of your symptoms using the symbols indicated below:

Aching ○	Burning #	Numbness ≈
Tingling ∧	Stabbing X	Shooting →



Is there anything else about you or your health that we should know?
_____
_____

Fort Langley Massage therapy & Holistic Health

AUTOMATED APPOINTMENT REMINDERS

If you have indicated participation, 24 hours before your scheduled appointment you will receive an 'Appointment Reminder/Confirmation' email/text. Please note that Fort Langley Massage Therapy only sends out confirmation and reminders via email and text. If you have opted out of the email/text option, please make a note of your appointment. PLEASE INITIAL HERE:_____

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 **24 HOURS NOTICE** so that we can fill the space. Should an appointment be cancelled with less than 24 hours notice, 100% of your scheduled appointment fee will apply. Should an appointment be missed entirely without any notice, 100% of the 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 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 the Massage Therapist I have booked appointments with. I understand that I am free to withdraw my consent and to discontinue participation in these procedures at any time.

Patient Name: _____

Guardian Name (if patient is a child): _____

Signature of Patient (or Guardian): _____

Date: _____