From Pain Relief to Wellness Care Naturally!!

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MASSAGE THERAPY INTAKE HISTORY FORM

Please tell us about you

Name: Dr/Mr/Mrs/Miss____

(**As it appears on your health card**)

Date: ____________________ Age: ______ Birthdate: d______m______y______

Height: ________________ Weight: ________________ Shoe Size: ____________

Address: _______________________ City: ____________ Postal Code: ____________

Email: _____________________________________ Occupation: ___________________

Home #: _________________ Work#: _________________ Cell# __________________

Who can we thank for referring you to us? _______________________________________

Other family members under our care: ____

CONTEXT OF CARE OVERVIEW;

What is your general health status.

____

____

Current medications and conditions it treats.

____

____

Surgeries and date of operation.

____

____

Health History

Please indicate conditions you are experiencing, or have experienced:

Respiratory

__ chronic cough
__ shortness of breath
__ bronchitis
__ asthma
__ emphysema

Cardiovascular

__ high blood pressure
__ low blood pressure
__ CCHF
__ heart attack
__ stroke/CVA
__ phlebitis
__ pacemaker or similar device

Other conditions

__ loss of sensation
__ diabetes (onset: _________)
__ allergies___________________
(ie. anaphylaxis or skin irritation)
__ cancer
__ epilepsy

Skin
__ skin conditions____

Infections
__ hepatitis
__ TB
__ HIV

Head/Neck
__ vision problems
__ vision loss
__ ear problems
__ hearing loss

Soft tissue/Joint discomfort
__ neck________________
__ low back_____________
__ mid back_____________
__ upper back___________
__ shoulders____________
__ arms________________
__ legs_________________
__ knees_______________
__ other________________

Women
__ pregnant due date____

*Primary care physician*____
Address____

Present involvement in other health care. Yes____ No______
If yes, please specify____

Other medical conditions (eg. digestive conditions, gynecological conditions, hemophilia etc.)
____
____

Of special note (presence of internal pins, wires, artificial joints, special equipment)
____
____

Please sign below after consulting with your therapist

I, ________________________________ consent to the treatment as described and explained to me by my therapist. I acknowledge that my therapist has provided me with information pertinent to the treatment and agree to receive it. I understand that my therapist will collect personal information as an individual practitioner to provide massage therapy, to help assess health care needs, make recommendations and to establish a baseline of healthcare information. I understand that the Massage Therapist will retain this form for 10 years from the last contact as regulated by the College of Massage Therapists of Ontario.

Signature X __________________________________ **Date**_______________________

Privacy Policy:
Your knowledge and consent are required before we may collect, use, or disclose your personal information except in rare circumstances (i.e. subpoena, medical emergency, and debt collection). If you have a question on any of this, please ask our office manager.
Massage Treatment Entails:
Assessment, reviewing the health history form with your therapist, massage and self-care advice at the end of the treatment.
First Visit:
Your RMT will review your Health History form with you and will ask questions to ensure that you receive a treatment that meets your needs. You will be asked to update this form yearly for address changes and any health-related changes that you're Registered Massage Therapist (RMT) should be aware of.
Illness
If you have a fever or a cough related to flu or cold symptoms, please call and reschedule your appointment. Massage is contraindicated for fevers and can exacerbate flu-like symptoms. Please leave a message for your therapist if you need advice.
Soft Scent Policy
Please refrain from using large amounts of perfumes, other scented products and refrain from smoking at least an hour before appointment.
Cell Phones
We ask that you do not make or receive phone calls on portable devices while in the clinic.
Lateness Policy
Clients are responsible for the time they reserve for their appointment. If you are late for your appointment the treatment will still end at the designated time with no change in fee.
CANCELLATION/MISSED POLICY
The Pickering Wellness Centre has a cancellation policy, when you book an appointment with a therapist you are booking that therapist's time. In order to accommodate all our clientele, we need 24-hour notice of cancellation, less than that is inadequate time for us to offer your appointment time to others. If you are unable to make it, we request that you call 24 hours in advance. If you do not call to cancel before the 24-hour period, a cancellation fee will be charged.

The fees for cancellation are as follows.

30 min.................... $24.00
60 min.................... $45.00
45 min.................... $34.00
90 min.................... $64.00

** All cancellation fees are subject to HST.
If you book within the 24hr time frame, the policy is in effect immediately. **I understand the 24-hour cancellation policy and agree to pay the missed appointment fee if I cancel within the 24-hour period preceding my appointment time. I understand Pickering Wellness's lateness policy that I am responsible to pay for the time I reserved with the therapist, regardless of the time I arrive, and I am ready for my appointment**.

Signature X ____________________________________ **Date:** ________________________

Thank you for your consideration and cooperation.