PICKERING WELLNESS CENTRE

From Pain Relief to Wellness Care Naturally!!
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MASSAGE THERAPY INTAKE FORM

For your information:

An accurate health history is important to ensure that it is safe for you to receive a massage treatment. If your health status changes in the future, please let us know. If you require more information about the health history questions being asked, please consult with your therapist. All information gathered for this treatment is confidential except as required or allowed by law except to facilitate diagnosis (assessment) or treatment. You will be asked to provide a written authorization for release of any information.

Today's date_____ Date of Birth_____
Name _____
Address_____
Home Phone_____ Business/Cell_____
Fax/email_____

Who referred you?_____
Their address _____
What is your primary complaint?_____
Occupation _____

Health History

Please indicate conditions you are experiencing, or have experienced:

What is your general health status:

_____
_____
_____

Current medications

_____
_____
_____

Condition it treats

_____
_____
_____

Surgery

_____
_____
_____
*Date*_____
*Nature*_____
_____
_____
_____

Injury

_____
_____

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, pleas specify_____

Other medical conditions (e.g. 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_____ 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 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 75 min..... $53.00
45 min..... $34.00 90 min..... $64.00
60 min..... $45.00

** 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: _____ Date: _____

Thank you for your consideration and cooperation.**