

Massage Therapy Intake & Consent Form

ABOUT YOU

Name: _____ Birth Date (Y/M/D) ____ / ____ / ____ Age: _____
 Address: _____ City: _____ Province: ____ Postal: _____
 Phone #: (home) _____ (work) _____ (cell) _____
 E-mail address: _____

How did you hear about maternity massage therapy: Friend – (who?) _____

Internet Rack card/Business Card Mail-out MD/Midwife Other _____

Emergency Contact: _____ Relation: _____ Phone #: _____

Regular Medical Doctor: _____ Also for maternity care

Maternity Healthcare Provider: _____ Doctor Midwife

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'm planning on having a one year maternity leave

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

- 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
<input type="checkbox"/> Massage Therapy	_____	_____	<input type="checkbox"/>
<input type="checkbox"/> Chiropractic Care	_____	_____	<input type="checkbox"/>
<input type="checkbox"/> Physiotherapy	_____	_____	<input type="checkbox"/>
<input type="checkbox"/> Acupuncture	_____	_____	<input type="checkbox"/>
<input type="checkbox"/> Naturopathic Care	_____	_____	<input type="checkbox"/>
<input type="checkbox"/> Other _____	_____	_____	<input type="checkbox"/>

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: _____

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 I 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 pays \$23 per treatment for up to 10 visits per calendar year. Payment for all treatment whether private or insured is ultimately the responsibility of the patient. At the clinic, we accept cash, debit, visa and mastercard for payment. For home visits I can ONLY accept CASH or CHEQUE (NSF fees apply). All fees include Government Sales Tax and are subject to change.

Fees for massage therapy treatments:

	<u>Initial Visit</u>	<u>Subsequent Visits</u>
Thirty minutes	\$60	\$45
Forty-five minutes	\$75	\$60
Sixty minutes	\$90	\$75
Seventy-five minutes	\$105	\$90
Ninety minutes	\$120	\$105

Additional forms of treatment can be added to your in-clinic visit at the following rates:

Paraffin therapy	\$10	
Stone therapy	\$20	(not if pregnant)

For HOME VISITS the above massage therapy fees apply as well as an additional TRAVEL FEE. If you live within 15 minutes of Active Health & Wellness Clinic a \$15 travel fee applies - within 30 minutes there is a \$30 travel fee. If there is more than one person having a massage during a home visit, the travel fee can be split between the massage participants.

As a courtesy, we will usually give you a reminder call the business day prior to your appointment, however; 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 I am late arriving for a home visit and need to shorten the treatment time, the fee will be adjusted accordingly.

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

I hereby state that the above information that I have filled in is true and accurate to the best of my knowledge. I authorize Elizabeth Belfry, RMT, CIMT & Active Health & Wellness Clinic to communicate with my Medical Doctor or Maternity Healthcare Provider as deemed necessary for my treatment. I understand that my personal and medical information (both written and spoken) is confidential and will only be disclosed to third parties with my permission. I also understand that I am expected to notify my RMT if there are any changes to my health/pregnancy OR if I am uncomfortable with ANY part of my massage therapy treatments.

I verify that I have read *Massage Therapy in the Childbearing Year: Patient Information* and am aware of the possible benefits and the contraindicated conditions for massage therapy during the childbearing year. I am aware that I need to consult with my Maternity Doctor/Healthcare Provider PRIOR to receiving massage therapy if I am a High Risk Pregnancy or am experiencing any contraindicated conditions in which it would be inadvisable for me to receive massage.

I understand that I will be receiving massage therapy as an adjunctive form of healthcare only, and that I must continue to receive appropriate medical care from my Medical Doctor/Maternity Healthcare Provider.

Patient Signature: _____ Print Name: _____ Date: _____

THANK YOU FOR YOUR COOPERATION IN THOROUGHLY COMPLETING THIS FORM ©