ARIA HEALTH & WELLNESS CLINIC
RMT INTAKE FORM

NAME: ______________________________ DATE: _________________________

BIRTH DATE: (M/D/Y) _______________ EMAIL: ____

ADDRESS: ____ POSTAL CODE: _______________

PHONE: (H) ___________________ (W) _____________________ (C) ______________________

CARE CARD #: _____________________________ OCCUPATION: ___________________________________

How did you hear of us: ____ (we like to say thank you!)

REASON FOR SEEKING TREATMENT: ____

Sport Traumas (type & date) ____

Medications and/or supplements: ____

Surgeries (type & date): ____

Car Accidents (date): ____

What exercise do you participate in: ____

Have you experienced massage therapy before Y / N

PLEASE CHECK ANY OF THE FOLLOWING CONDITIONS THAT PERTAIN TO YOU

Systemic Conditions

_ AIDS/HIV
_ Hepatitis A/B/C/D
_ Multiple Sclerosis
_ Parkinson's
_ Organ Transplant: ___________
_ High Blood Pressure
_ Low Blood Pressure
_ Diabetes Type I/ Type II
_ Cancer: __________________
_ Varicose Veins
_ Poor Circulation
_ Stroke
_ Implanted devices

Joint Conditions

_ Osteoporosis
_ Disc Herniation
_ Degenerative Disc Disease
_ Arthritis: ____________
_ Rheumatoid Arthritis
_Scoliosis
_ Gout

Digestive Conditions

_ Acid Reflux
_ Ulcer: ____________
_ Chron's
_ Chronic Constipation
_ IBS

Respiratory Conditions

_ Shortness of breath
_ Asthma
_ Smoker
_Emphysema
_COPD

Head & Neck Conditions

_ Headache
_ Sinusitis
_ Whiplash

Muscle Conditions

_ Sciatic Pain
_ Leg Cramps
_ Muscle pain:____________

Stress level 0 – 10:_________

Are you PREGNANT Y/N If YES due date:_____________

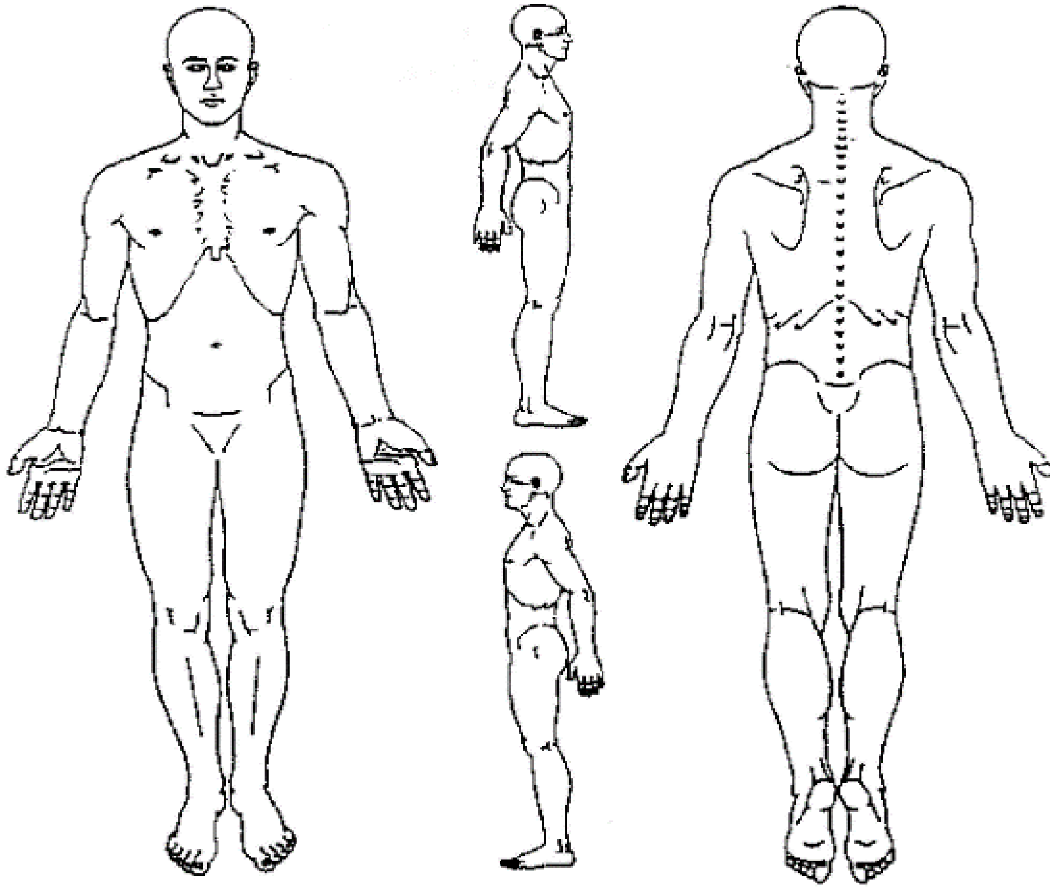
*Other conditions not listed _____________________________________

OTHER PRACTITIONERS YOU ARE CURRENTLY RECEIVING TREATMENT FROM:

_ Chiropractor _Physiotherapy _Osteopathy _ Naturopath _Acupuncture _Other:_________________

<u>Please draw with an "X" the location of your complaint on the picture or use the following symbol(s):</u>

Ache: AAA, Burning: BBB, Numbness: NNN, Pins/Needles: +++, Stabbing: ///, Stiff/Tight: 222, Shooting Pain: →→→



Name ________________________

ARIA HEALTH & WELLNESS CLINIC REGISTERED MASSAGE THERAPY CLIENT CONSENT FORM

I agree to pay the fees of treatment written below. Cancellation with less than 24 hours notice or missed appointments will be charged 50% of the scheduled appointment fee. Missed appointment charge will not be covered by MSP or my extended medical plan; it must be paid by me, the client.

30Min:	$64.05
45min:	$85.05
60 Min:	$99.75
90 Min:	$141.75

All prices include GST

Initial: ___________

If I am using MSP coverage, the clinic will deduct $23 per visit and I am responsible for paying the remaining amount. When the MSP coverage is exhausted, I agree to pay the full amount for treatment. Initial: __________

The possible risks and side effects that may or may not occur from the results of treatment received have been clearly explained and I fully understand them. I understand that if I withhold pertinent health history information, the proposed outcomes of treatment may not be reached and I may be putting myself at risk. Initial: _________

I authorize the clinic and its associated RMTs to collect my personal and medical information as documented above in order to contact me, and give permission for the clinic to leave messages regarding appointments at any of the contact numbers I have provided above. In addition, I authorize the clinic and its associated RMTs to communicate with my referring Health Provider/MD as deemed necessary for my beneficial treatment. I also understand that my personal and medical information is confidential and will only be disclosed to third parties with my permission. Initial: __________

I agree to receiving appointment reminders via email. I acknowledge that if I opt out of this service and I miss my appointment, I will be charged for the missed appointment.

Initial: ___________

Yes, I want to receive emails about community news from Aria Health & Wellness Clinic.

Initial:___________

I have read the above and give my informed consent to treatment.

Client Signature: _____________________ Date:_________________