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:_____

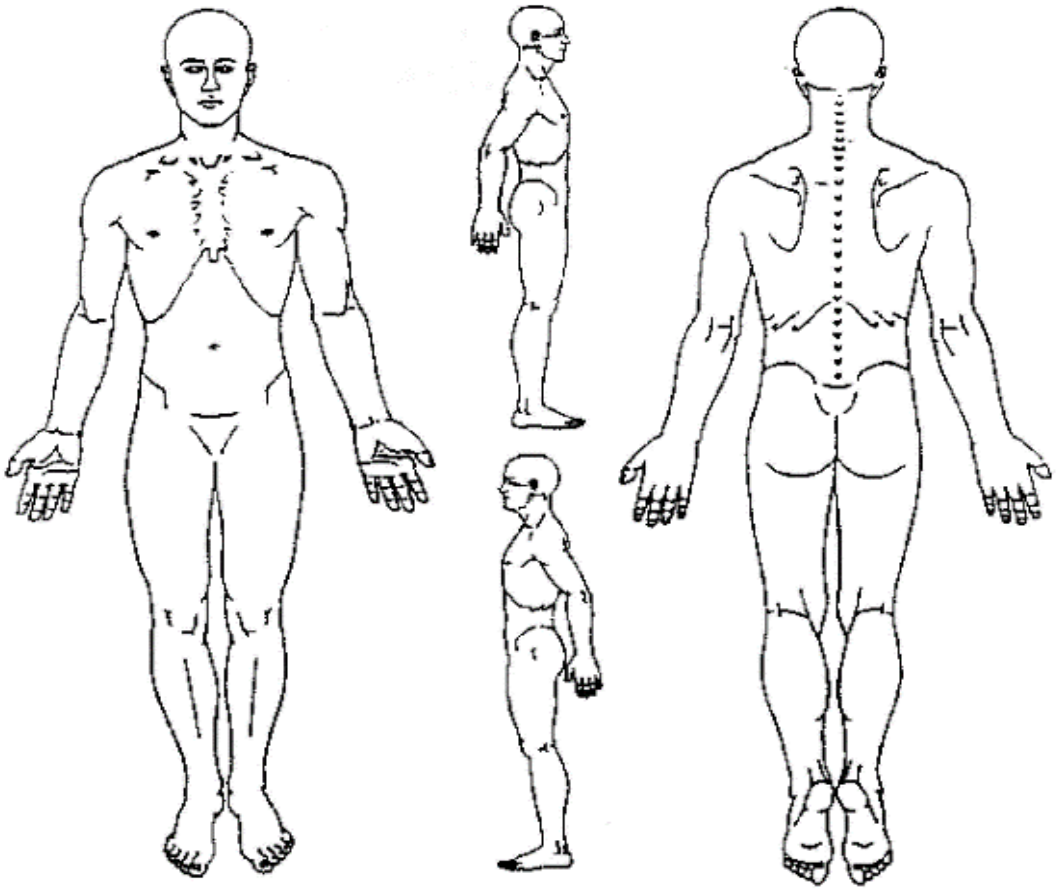
*Other conditions not listed _____

OTHER PRACTITIONERS YOU ARE CURRENTLY RECEIVING TREATMENT FROM:

_ Chiropractor _Physiotherapy _Osteopathy _ Naturopath _Acupuncture _Other:_____

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

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:_____

PRENATAL RMT INTAKE FORM
ARIA HEALTH & WELLNESS CLINIC

Main area of concern: _____

Due Date: _____ Number of weeks: _____

Current Health History:
Doctor/Midwife: _____ May we contact? Y / N
List any Medications, Herbs, Supplements: _____
Do you have a birth plan? Y/ N If so, please describe: _____
Do you have a planned cesarean birth? Y/N Date: _____ If so, why: _____
Are you planning a VBAC? Y/ N
Are you considered a High Risk Pregnancy? Y/ N Please list any complications: _____

Past Prenatal Health History:
Is this your first pregnancy? Y/ N If no: How many times have you been pregnant: _____
How many full term babies: _____ Ages of children: _____

How is this pregnancy similar or different from your previous pregnancies:
_____
Deliveries: Vaginal ___ Cesarean Birth ___ if so, why: _____
Did you have any complications healing from either vaginal or cesarean birth? Y / N
If so, why: _____

Lifestyle/General Health & Wellbeing:
How is your sleep: _____ Are you rested? Y / N Position: _____
What exercise do you participate in: _____

Current Conditions:

__Acid Reflux	__ Dizziness	__ Nausea
__ Anxiety	__ Edema/swelling	__ Numbness/ Tingling
__ Back/Neck/Shoulder Pain	__ Fever	__ Sacral/Tail Bone Pain
__ Carpal Tunnel Syndrome	__ Gestational Diabetes	__ Skin Conditions: _____
__ Constipation/Diarrhea	__ Head Ache	__ Vomiting
__ Varicose Veins		

Previous Health Conditions:

__ Autoimmune Disease	__ High Blood Pressure	__ Post Partum Depression/anxiety
__ Blood Clots	__ Infertility Challenges	__ Miscarriage(s)
__ Chronic Pain	__ Joint problems	__ Surgeries
__ Heart disease	__Vertebral disc issues	__ Other: _____

What other practitioners/treatments are you seeking and/or receiving during pregnancy:
_____

Any additional information you would like to share: