Registered Massage Therapy Patient Intake Form

Carlisle Family Chiropractic: 1490 Centre Road, Carlisle, ON L0R 1H2 P: 905.689.5100

A fully completed and accurate health history form is important so that your therapist can design a safe and effective treatment plan that is specific to and appropriate for your needs. Please fill out this form to the best of your ability.

Full Name: _____ **Date of Birth:** _____

Address: (Street)_____

(City)_____ (Postal Code)_____

Home #:_____ **Cell:**_____ **Email:**_____

Please check your preferred option(s) for appointment reminders: ☐ **Call** ☐ **Text** ☐ **Email**

Occupation: _____ **Regular Activities/Sports** _____

Have you received this type of treatment before? ☐ **Yes** ☐ **No**

What is your main reason for seeking treatment today? _____

Health History

Current medications & conditions they treat: _____

_____

Surgeries (approximate date), **pins, wires, etc…** _____

_____

Have you been in any Motor Vehicle Accidents? ☐ **Yes** ☐ **No** **If Yes, approx. date:** _____

Please check all applicable boxes below "C" for currently and "P" for in the past.

Cardiovascular
__ Blood pressure
__ Heart disease
__ Heart attack
__ Stroke
__ Pacemaker
__ Varicose Veins
__ Blood Clots
__ Lymph/Edema
__ Hemophiliac

Digestive
__ Constipation
__ Gas/Bloating
__ Irritable Bowel Syndrome
__ Crohn's Disease
__ Liver/Gallbladder
__ Kidney/Bladder
__ Nausea/Vomiting

Musculo-Skeletal
__ Osteoarthritis
__ Rheumatoid arthritis
__ Bursitis
__ Tendonitis
__ Fractures
__ Sprains/Strains
__ Stiffness
__ Swelling
__ Pain/Tension
Where? _____
_____

Respiratory
__ Asthma
__ Emphysema
__ Bronchitis
__ Chronic Cough
__ Shortness of breath

Infectious Diseases
__ Hepatitis
__ Tuberculosis
__ HIV
__Other _____

Skin
__ Eczema/psoriasis
__ Rashes
__ Cold Sores
__ Athletes foot
__ Warts
Where? _____
_____

Reproductive
__ Menopause
__ Current Pregnancy
Trimester_____

Other
__ Numbness/tingling
__ Chronic Fatigue
__ Fibromyalgia
__ Epilepsy
__ Diabetes: Type ____
__ Cancer
Type? _____
__ Migraines
__ Headaches
__ Shingles
__ Allergies
To what? _____

Mental Health
__ Anxiety/Panic
__ Depression
__ Phobias _____
__ Other _____

Do you have any other health concerns not addressed here: _____

Stressors

On a scale of 0 to 10, please indicate your current level of stress 0 1 2 3 4 5 6 7 8 9 10

How many hours do you tend to sleep on an average night? _____ Do you wake refreshed Y N

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Informed Consent for Massage Therapy

The following section covers informed consent for treatment and assessment of the areas specified by you, the patient, below.

Consent for Areas to be Treated

In accordance with the College of Massage Therapists of Ontario standards of practice, when the assessment or treatment of sensitive areas (as listed below) is indicated or requested, it is important that you, the client, fully understand the nature and purpose of this treatment. This written consent form will act as a record of our discussion pertaining to your plan of treatment. If you have any questions, during our discussion or while completing this form, please do not hesitate to ask.

I, _____, have requested assessment/treatment of the:
(please **INITIAL** beside the areas you would like to have treated)

Standard Areas of Treatment:

____ general massage treatment
(may include any combination of the following areas: back, neck, shoulders, legs, arm, feet, hands and scalp)

Sensitive Areas require specific and on-going consent when indicated for treatment:

____ adductor/upper inner thigh area

____ buttock/gluteal muscles

____ breast area or chest wall muscles

____ Abdominal muscles & Deep Hip Flexors

for the purpose of: recovery from surgery, scar improvement, medical massage, reduction in pain, improved range of motion, relaxation and/or reducing muscle tension.

Client Consent Statement

In keeping with the Health Care Consent Act (1996), it is my choice to receive treatment. I understand that an assessment by a therapist is required to determine the best course of treatment. I am aware that all information provided is private and confidential and will not be released without my written consent. I agree to communicate with my therapist at any time if I have any questions or concerns, if I feel uncomfortable or if I feel my well-being is being compromised. I understand that there may be some mild side effects from treatment such as temporary muscular discomfort, bruising and possible dizziness post treatment. (24-48 hours post treatment). I am also aware that the clinic is not responsible for any lost, stolen or damaged articles.

I have discussed the assessment and/or treatment plan with_____. During this discussion; we adequately covered: (please **INITIAL** each area)

____ That consent is voluntary

____ areas to be assessed/treated,

____ alternative courses of treatment

____ that consent can be altered at any time

____ the benefits, risks & side effects of assessment/treatment

____ the clinical reasons for assessment/treatment

____ positioning/draping to be used on areas being treated

____ likely consequences of not having assessment/treatment

I have read and understood the above information. I intend this consent form to cover the entire course of treatment for my present condition and for any future condition(s) for which I seek treatment.

_____
Print Patient's Name

_____ _____
Patient Signature (or Parent/Guardian for those under 16) Date

_____ _____
RMT Signature

Patient update	Initial:	____	____	____	____	____	____	____	____	____	____
	Date:	____	____	____	____	____	____	____	____	____	____