

Registered Massage Therapy Intake Form

**Personal Informa�on:**

|  |  |
| --- | --- |
| Name: *Last* \_\_\_\_\_\_\_\_\_\_\_\_\_\_ *First* \_\_\_\_\_\_\_\_\_\_\_\_\_ *Middle* \_\_\_\_\_\_\_\_\_\_\_\_\_ | Sex: M/F |
| BC CareCard#: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Birth: (mm/dd/yyyy) \_\_/\_\_/\_\_\_\_ | Age: \_\_\_ |

Home Address: *Street* \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ *City* \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

*Postal Code* \_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone: Home \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Cell \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Email: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

|  |  |  |  |
| --- | --- | --- | --- |
| Employer: |  |  |  |
| \_\_\_\_\_\_\_\_\_\_\_\_\_\_ Occupa�on: \_\_\_\_\_\_\_\_\_\_\_ Work Phone: | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| How did you find out about us? (Please check) |
| ( ) Signboards/ Just passed by |
| ( | ) Flyer/ Brochure |
| ( | ) Friend/ Rela�ve:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| ( | ) Doctor: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| ( | ) Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |

**ICBC Claim or Extended Healthcare Benefits:**

Claim Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Accident: (mm/dd/yyyy) \_\_/\_\_/\_\_\_\_

Case Manager: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

|  |  |  |  |
| --- | --- | --- | --- |
| Ο Paci c Blue Cross | Ο Sun Life Financial | Ο Chambers of Commerce Ο Desjardins | Ο Industrial Alliance |
| Ο Johnston Group | Ο Maximum Benefit | Ο Great-West Life | Ο Johnson Inc. Ο Manulife | Ο GreenShield |
| Ο Cowan Ο RCMP | Ο Veteran Affairs Canada | Policy Number:\_\_\_\_\_\_\_\_\_\_\_\_ |
| Ο Other :\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | Member ID:\_\_\_\_\_\_\_\_\_\_\_\_ |
|  |  |  |

**The following informa�on will be used to help plan safe and eﬀec�ve massage sessions. Please answer the ques�ons to the best of your knowledge.**

What/Where is your pain/problem? Please circle on the diagram below

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you know what caused it?

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

How would you rate the pain?

|  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 |

When did it start?

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

What would aggravate the pain/problem?

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

What would relieve the pain/problem?

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Con�nued on page 2



**Medical History:**

In order to plan a safe and eﬀective massage session, please provide general information about your medical history.

Do you have any allergies? If yes, please explain

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Are you taking any medication? If yes, please list

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Are you pregnant? If yes, how many months? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Please check any condition listed below that applies to you

|  |  |  |  |
| --- | --- | --- | --- |
| \_\_Contagious skin condition | \_\_Allergies/sensitivity | \_\_Rheumatoid arthritis | \_\_Back/neck problems |
| \_\_Open sores or wound | \_\_Heart condition | \_\_Osteoarthritis | \_\_Fibromyalgia |
| \_\_Easy Bruising | \_\_High or low blood pressure | \_\_Tendinitis | \_\_TMJ dysfunction |
| \_\_Recent accident or injury | \_\_Circulatory disorder | \_\_Osteoprorosis | \_\_Carpal tunnel syndrome |
| \_\_Recent fracture | \_\_Varicose veins | \_\_Epilepsy | \_\_Tennis/golf elbow |
| \_\_Artifical joint | \_\_Atherosclerosis | \_\_Headaches/migraines | \_\_Frozen shoulder |
| \_\_Sprains/strains | \_\_Phlebitis | \_\_Cancer |  |
| \_\_Current fever | \_\_Deep v~~e~~in thrombosis | \_\_Diabetes |  |
| \_\_Swollen Glands | \_\_Joint disorder | \_\_Decreased sensation |  |

Please list any major surgery and the year when it was performed.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Is there anything else about your health history that you would like to add?

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Acknowledgement:**

PRIVACY AND SHARING OF INFORMATION

I authorize **Kerrisdale Physiotherapy (PrecisionCare)** and its associated health professionals to collect my personal and medical information as documented above. In addition, I authorize **Kerrisdale Physiotherapy (PrecisionCare)** and its associated health professionals to communicate with my family physicians, specialists, case managers, adjusters and/or referring doctor as deemed necessary for my beneficial treatment.

CANCELLATION POLICY

Your appointment time is reserved just for you. A late cancellation or missed visit leaves a hole in the therapists' day that could have been filled by another patient. As such, we require 24 hours notice for any cancellations or changes to your appointment.

I understand that in the event that I fail to provide 24hrsadvanced notice to cancel my appointment a cancellation fee will be imposed. This cancellation fee is in accordance with the most current fee schedule setfor the therapist I would have seen.

CONSENT TO REGISTERED MASSAGE THERAPIST TREATMENT

I hereby give **Kerrisdale Physiotherapy (PrecisionCare)** and all healthcare professionals working under that entity

consent to treatment and will not hold these bodies responsible for the outcome of such treatment with the understanding that treating therapists and healthcare professionals will practice within their scope of practice as set forth in the Health Professions Act and within the guidelines of their respective professional governing authorities. I also understand that a typical treatment session may involve body exposure and tissue palpation for the purposes of examination and/or treatment; furthermore, a gown is always available to me, and I am not obligated to remove any article of clothing if I feel uncomfortable doing so. I am free to ask pertinent questions that relate to my condition as well as the examination process and have the right to refuse treatment at any time. 

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Client Signature (or Legal Guardian) Signature of Witness

Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_