The HEALING PATH
Chiropractic & Wellness Centre

Massage Therapy Confidential Patient Intake Form

The information requested below will assist us in treating you safely. Feel free to ask any questions about the information being requested. Please note that all information provided will be kept confidential unless allowed or required by law. Your written permission will be required to release any information outside The Healing Path.

Today's Date (M/D/Y):			
LAST NAME:	**FIRST NAME:**	**Date of Birth (M/D/Y):**	
AGE	**Legal Guardian** (permission required if patient is under 16 years of age):		
Address:	**City:**	**Prov:**	**Postal Code:**
Home #: ☐preferred	**Cell #:** ☐preferred	**Work #:** ☐preferred	
Email:_____ May we send you your appointment reminders via email? ☐Yes ☐No May we send you clinic notifications/updates via email? ☐Yes ☐No			**Gender** ☐ Male ☐ Female
Occupation:			
Family Physician's Name:	**City:**	**Phone#:**	
Emergency Contact:	**Relationship:**	**Phone#:**	
How did you hear about our office? ☐ Physician:_____ ☐Social Media ☐Signage ☐ Family/ Friend: _____ ☐Website ☐Live in the area			

Massage Therapy Health History Form

Please check ☑conditions you are currently experiencing or have experienced in the past.

MUSCLES/JOINTS *Please indicate the right or left side where appropriate*

☐ Upper back	R	L	☐Wrist	R	L	☐Weakness/loss of strength	☐Tendonitis		
☐ Mid back	R	L	☐Hand	R	L	☐Clumsiness	Location:_____		
☐ Lower back	R	L	☐Hip	R	L	☐Multiple Sclerosis	☐Strain		
☐ Shoulders	R	L	☐Leg	R	L	☐Muscular Dystrophy	Location:_____		
☐ Elbows	R	L	☐Knee	R	L	☐Arthritis	☐Joint sprain/dislocation		
☐ Arm	R	L	☐Ankle	R	L	☐Osteoarthritis	Location:_____		
☐ Neck	R	L	☐Foot	R	L	☐Rheumatoid arthritis	☐Artificial joints/pins/wires/screws		
						☐Orthotics	Location:_____		

SKIN

☐ Rashes/bruises easily ☐Infectious skin conditions
☐ Contagious skin conditions ☐Other:_____
☐ Skin allergies

HEAD/NECK

☐ Visual impairment ☐Sinus problems
☐ Hearing impairment ☐Jaw pain (TMJ pain)
☐ Hearing aid ☐Headache/migraine
☐ Speech impairment

RESPIRATORY

☐ Asthma ☐Difficult breathing
☐ Bronchitis ☐Shortness of breath
☐ Chronic cough ☐Smoking
☐ Emphysema ☐Other:_____

CARDIOVASCULAR

☐ High / low blood pressure ☐Stroke / cerebral vascular accident
☐ Bleeding disorder ☐Pacemaker / internal defibrillator
☐ Hemophilia ☐Varicose Veins
☐ Arteriosclerosis ☐Phlebitis
☐ Heart attack ☐Poor circulation
☐ Angina ☐Other:_____

WOMEN

☐Pregnant? Due Date:_____
No. of children:_____
☐Gynecological Conditions: _____

INFECTIOUS CONDITIONS

☐ Herpes/STDs ☐Tuberculosis(TB)
☐ Hepatitis:_____ ☐Other:_____
☐ HIV /AIDS

OTHER CONDITIONS

☐ Cancer ☐Anxiety
☐ Diabetes ☐Depression
☐ Fainting ☐Vestibular / balance problems
☐ Insomnia ☐Chronic pain
☐ Kidney problems ☐Fibromyalgia
☐ Numbness/tingling ☐Epilepsy

PAST INJURIES OR SURGERIES

☐ **Fractur**es/**Injuries**
1. _____
2. _____
3. _____

☐ **Surgeries**
1. _____
2. _____
3. _____

MEDICATIONS& ALLERGIES

Please list all medications you take and for what conditions: _____._____ _____
_____
Please list any allergies you have: _____
_____

CURRENT SYMPTOMS (*check all that apply)*

☐ Chest pain	☐Headaches	☐Coordination problems	☐Visual problems
☐ Loss of balance	☐Weakness	☐Decreased range of motion	☐Pain at night
☐ Hearing problems	☐Difficulty sleeping	☐Difficulty concentrating	☐Vertigo /dizziness

☐ Other:_____
How long have you had the above symptoms?_____
What makes your symptoms worse?_____Better?_____
On a scale of 1-10 (with 0 being no pain and 10 being the worst pain) How would you rate your pain? 0 1 2 3 4 5 6 7 8 9 10
What do you consider your General Health Status to be: _____

Signature:_____ Date_____
Signature: _____ Date _____
Signature:_____ Date_____
Signature: _____ Date _____
Signature:_____ Date_____

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MASSAGE THERAPY CONSENT FORM

INFORMED CONSENT TO MASSAGE THERAPY TREATMENT and RELEASE OF INFORMATION

I, the undersigned, voluntarily consent to the registered massage therapists ("RMT") and The Healing Path (the "Clinic") providing massage therapy services (the "Treatment") to me, now and on an ongoing basis, with such Treatment to be within the scope of the RMT practice as defined by the College of Massage Therapist of Ontario including without limitation, such assessments, examinations and techniques, as recommended by the RMT. I consent to the RMT undraping areas of my body to the extent needed to provide Treatment while considering my comfort, security, and privacy as requested by me. I understand that at any time I may withdraw my consent to Treatment by informing the RMT with words to that effect, and then Treatment will be stopped. _____(Initial) ←

I agree that Treatment is not a substitute for a medical examination and diagnosis by a medical physician. I agree that no assurance or guarantee has been provided to me by RMT or the Clinic as to any results of Treatment._____(Initial) ←

POSSIBLE RISKS ASSOCIATED WITH TREATMENT

I agree that my consent is given while informed of the fact that possible and likely risks to me exist during the course of Treatment, including, but not limited to, muscle strains and sprains, bruising, light headedness, dizziness and tenderness. I agree that the RMT is not able to explain unanticipated risks and complications and as such there may be other risks associated with Treatment in addition to those identified above.

_____(Initial) ←

DUTY TO DISCLOSE MEDICAL HISTORY

I agree that I have a duty to fully disclose to the RMT and Clinic all medical conditions affecting me, whether or not I believe any medical condition is applicable or relevant to my Treatment. I further agree that it is my responsibility to keep the RMT updated and informed of my medical condition. I declare that the information I have provided in the above Medical History Form is true, accurate and complete._____(Initial) ←

DISCLOSURE OF PERSONAL INFORMATION

I understand that it may be desirable from time to time for the RMT and Clinic to coordinate my health care with others, including but not limited to other Clinic staff, physicians, other health care providers, case managers, and insurance claim adjusters ("Other Providers"), which results in disclosing my personal information (as defined in the Personal Information Protection Act (the "Act"). I consent to the RMT and Clinic disclosing my personal information to Other Providers, when done in accordance with the Act. I consent to the shared access between the RMT and the Clinic staff to my personal information. I agree that I must expressly withdraw consent of the disclosure of my personal information by providing 2-business day notice of such withdrawal of consent in writing to the RMT and Clinic.

_____(Initial) ←

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AGREEMENT TO FEES

I understand that I am solely responsible for paying the fee associated with each treatment session. I agree to pay this fee that is in accordance with the most current fee schedule at the time of each visit.

30 minutes: $50.00 + tax 45 minutes: $70.00 + tax
60 minutes: $90.00 + tax 90 minutes: $125.00 + tax

_____ (initial) ←

CANCELLATION POLICY

CANCELLATION FEE = HALF OF THE APPOINTMENT FEE

I understand that in the event that I fail to provide **at least 24 hours** of advanced notice to cancel my appointment a cancellation fee, half the appointment fee, will be charged. _____ (Initial) ←

This cancellation fee is half of the appointment fee without exceptions, including MVA clients, and at your personal expense_____ (initial) ←

By signing below I agree that I have read and understood the above information and that I have had the opportunity to ask the RMT and or our office staff any questions regarding the contents of this consent and treatment form.

Patient Name (please print): _____

Patient Signature (or Legal Guardian): _____

MASSAGE FORMS FOR CONSENT TO TREAT SENSITIVE AREAS

In maintaining the standards of practice stated by the College of Massage Therapists of Ontario, you are now required to give written consent for the treatment of sensitive areas of the body.

You will be giving consent for the Registered Massage Therapists(RMT) at The Healing Path, to treat sensitive areas. Please check the sensitive areas that you are voluntarily giving consent to have treated if deemed clinically necessary.

- ☐ Gluteal (buttocks) area
- ☐ chest wall / breast area
- ☐ inner thighs / groin
- ☐ chest wall

You are required to verbally give consent at the start of every treatment, for treatments that involve the gluteal area, breast, chest wall, and groin. _____ (initial) ←

You and or the RMT are able to stop treatments at any time if there is discomfort or uneasiness with any techniques, pressure, draping, or areas treated during the treatment. _____ (initial) ←

Patient Signature and Date: _____

Patient Signature and Date: _____

Patient Signature and Date: _____

Patient Signature and Date: _____

Patient Signature and Date: _____

Patient Signature and Date: _____

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Patient Signature and Date: _____

Patient Signature and Date: _____

Patient Signature and Date: _____

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