Back to Back Massage Therapy Intake Form

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Fees and Cancellation Policy:

Please check with each massage practitioner for massage prices, as they are individual to each practitioner. Massage therapists cannot bill directly to MSP, ICBC, WCB and select healthcare plans. Payment of your massage session is due at the time of each visit.

If you are unable to make your massage appointment, 24 hours' notice is required. In cases of missed appointments, or when insufficient notice of cancellation is given, you will be **charged a NO SHOW/Late Cancellation Fee equal to the appointment fee**.

Appointment fees are as follows:	Initial	$100.00
	30 min.	$60.00
	45 min.	$80.00
	60 min.	$100.00

I have read and understand the No show/Cancellation policy. I agree to pay any fees for missed appointments that fall under this policy.

_____ _____

Printed Name: Signature:

Date: _____/_____/_____
MM DD YY

Please note: While we try to remind you of your appointment the day before, it is best **not** to rely on reminder calls, texts and emails. Also, we **do not** book, cancel or reschedule appointments by email or text, please give us a call and we'd be more than happy to assist you with any booking changes.

CONSENT to TREATMENT & RECORD SHARING

Patient name: _____ DOB: (dd/mm/yy): ____/____/____

- **Please read this document, including Schedule A (on page 4), carefully and completely. It is important.**
- Ask your RMT any questions you have about this form or its contents BEFORE you sign this document.
- Ask questions about your treatment at ANYTIME.
- Immediately advise your RMT if you become uncomfortable in any way with your treatment.

The Treatment: I authorize and consent to the RMT performing the following treatments on me:
Soft Tissue Mobilization: _____ Joint Mobilization: _____Exercise Therapy/homecare: _____
Trigger Point Therapy: _____ Hydrotherapy Hot/Cold: ___Myofascial Release Technique: ____
(IASTM: Instrument assisted soft tissue manipulation):_____ Other: _____

Risks, Complications and Side Effects: **my initials indicate that I acknowledge and understand that:**

_ There are risks associated with Massage Therapy. Examples include: bruising, aching, discomfort, short term aggravation of symptoms and skin irritation.

_ My RMT has discussed with me the nature of purpose of the proposed treatments, the possible alternative methods of treatment, the risks involved and the possible complications and side effects.

_ I have discussed my concerns about possible risks with my therapist BEFORE signing this document. If I develop a concern after signing, I agree to discuss the same with the RMT immediately.

Disclosure of Medical History: my initials indicate that I acknowledge and understand that:

_ It is important for the RMT to know my relevant medical history.

_ I have disclosed to the RMT all medical conditions, including any mental or emotional conditions for which I have received treatment within the last 12 months.

_ I will disclose any new such condition that may develop after my completion of this form.

_ The information disclosed by me is true and complete to the best of my knowledge.

_ Sharing of My Patient Record: My initials confirm that I request and authorize my RMT to provide to the clinic and to other health care practitioners who provide me with treatment, copies of any patient record created by my RMT. I understand that I may revoke this permission in writing at any time in the future.

Confidentiality: The contents of this form and my patient records will be kept confidential unless I have expressly or impliedly consented to the release of my information or where there is a legal requirement to provide my information to a third party.

No Guarantee of Results: I acknowledge and confirm that no guarantee or assurance of results has been made to me regarding my treatments.

_____ _____

Patient Signature* **Date**: (dd/mm/yy)

(*in the case of a person incapable of providing consent, signature of Parent or Guardian, in which case the name & Relationship of person signing: _____)

Patient Basic Information:

Address:_____ Birth Date:_____Care Card:_____

_____ Occupation:_____

Home Phone:_____ Emergency Contact:_____

Work Phone:_____ Cell Phone:_____

Medical Doctor:_____ Email: _____

Please check the type of reminder you would like: Text____ (Cell phone provider :_____) Email ____

PLEASE LIST ALL ALLERGIES: _____

1. Reason for seeking care/major complaint(s):

1) _____

2) _____

3) _____

2. Onset of pain: ❍ Sudden ❍ Gradual ❍ Injury Cause of Injury: _____

3. On a scale of 1-10 (0 being no pain to 10 being unbearable pain):

How would you rate your pain today? _____ How would you rate your pain on average? _____

4. What aggravates the pain? _____

5. What relieves the pain? _____

6. Has this condition occurred before? ❍ No ❍ Yes If yes, how so? _____

7. How does the pain affect your daily routine? _____

_____

8. Please list all medications you are currently taking: _____

_____

9. Are you currently seeing any other practitioners?

❍ R.M.T. ❍ Physiotherapist ❍ Chiropractor ❍ Acupuncturist ❍ Other _____

10. Please list ANY accidents, illnesses, or other injuries: _____

_____

11. Do you have/wear: ❍ Implants ❍ Steel Pins ❍ Foot Supports ❍ Glasses/Contact Lenses

Other: _____

12. Are you satisfied with your:

Overall Health:	❍No ❍Yes	Ability to Relax:	❍No ❍Yes	Sleep:	❍No ❍Yes
Energy Level:	❍No ❍Yes	Fitness Level:	❍No ❍Yes	Diet:	❍No ❍Yes

13. Medical History - Please mark all that apply to you: ✗ = Past ✓= Present

❍ Allergies	❍ Fractures	❍ Insomnia
❍ Arthritis	❍ Head Injuries	❍ Jaw Pain
❍ Cancer	❍ Headaches	❍ Respiratory Issues
❍ Circulatory Condition	❍ Heart Condition	❍ Seizures
❍ Contagious Condition	❍ Hepatitis A/B/C	❍ Skin Condition
❍ Diabetes	❍ High/Low Blood Pressure	❍ Spinal Injury
❍ Dislocation	❍ HIV/AIDS	❍ Sprains/Strains
❍ Fainting	❍ Infection	❍ Stroke

❍ Pregnant: _____ Or trying to conceive? _____

❍ Please list any pregnancy complications you have or have had? _____

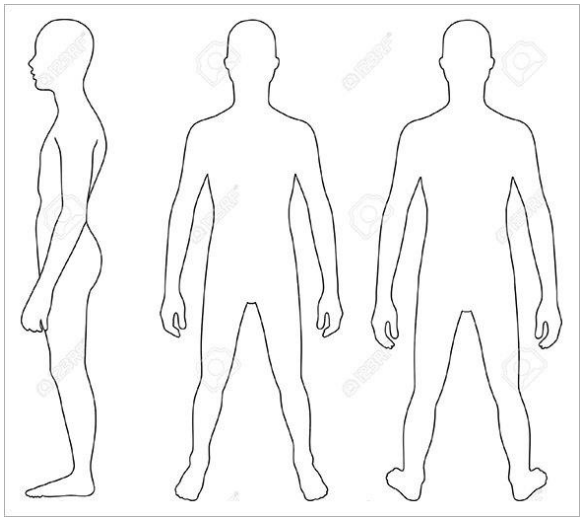
❍ Other: _____

Schedule A
To consent to Treatment of

Patient Name:_____ Date: ____/____/____

Body Areas to be treated:

I acknowledge and confirm that the areas of my body circled on the diagram below may be touched by the RMT during the course of my treatments:



I acknowledge and confirm that it may be necessary for the RMT to adjust their treatment plan during my treatment, in which case they will discuss that with me.

Patient signature*: _____ Date: ____/____/____

(*in the case of a person incapable of providing consent, signature of Parent or Guardian, in which case the Name and Relationship of the person signing: _____)