Confidential Client History - Intake Form & Consent to Treatment

The more informed the therapist is about you, the more comprehensive our treatment plan can be for you.

Name _____

Address _____ City _____

Email_____ Prov _____Postal Code _____

Cell_____ Home_____ Occupation: _____

Preferred way to be contacted: ❒Email ❒Cell by text ❒Cell by call ❒Home phone **"When" is best**:_____

Emergency Contact: Name_____ **Relationship**_____ **Phone**_____

Referred by: **Name**_____ **Relationship**_____ **Phone**_____

I give my permission to thank the person who referred me? ❒Yes ❒No ***Their Text/Email*** _____

❒Female ❒Male. Transgender ❒F ❒M. DOB: _____(m) ____(d) _____(y). Height:_____Weight:_____. Dominant Hand: ❒Left ❒Right

YOUR MAIN REASONS or **GOALS FOR SEEKING MASSAGE**:_____

_____

_____

_____

KEY MEDICAL CONDITIONS_____

_____

_____

MEDICATIONS

Purpose for Meds_____ Side Effects_____

Purpose for Meds_____ Side Effects_____

Purpose for Meds_____ Side Effects_____

INFECTIOUS CONDITIONS: _____

Inform therapist if you are currently experiencing a "flare up" of any infectious condition.

_____

Have you had massage before ❒ No ❒ Yes. What was your experience?_____

_____

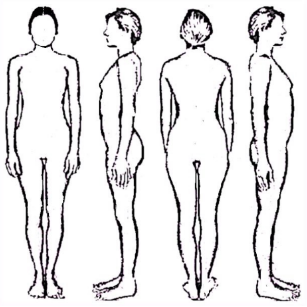
PRECAUTIONS (areas to avoid, sensitivities or approaches you dislike)_____

_____

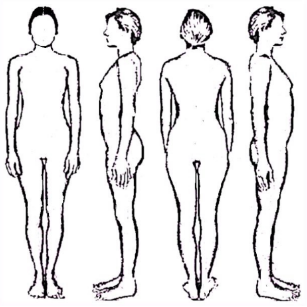
PREFERENCES (what areas are your "favourites" for helping you to relax or feel at ease) _____

_____

this is for **YOU** to draw on



below is for **THERAPIST**



CURRENT SYMPTOMS:

Current region of your body	1)	2)	3)
sensation			
intensity 1-10	(1=low)		
quality			
onset			
frequency			
duration			
what relieves			
what aggravates			

HISTORY: TRAUMA / INJURY / ACCIDENT /SURGERY / CONDITION

YEAR	Body REGION	Historic INCIDENT

WELLBEING. This is more about **your sense** of how "*what you are doing*" is "*working for you*" (& not about being correct or incorrect).
Rank (1= low, 10=high) Physical____/10 **Emotional**____/10 **Mental**____/10 **Energetic** ____/10
Ability to relax……. ____ /10 What helps?_____
Diet…….. ____ /10 Focus? _____
Bowel Movements… ____ /10 Average number of bowel movements a day_____
Water Intake ……. ____ /10 Daily Water Intake range: _____to_____❒ cups ❒ litres Type of Water(s):_____
Habits: quantity/frequency ❒Alcohol_____ ❒Caffeine_____ ❒Smoke_____. ❒Eat / ❒Avoid: ❒Wheat ❒Dairy ❒Sugar
Do you have any issues with your selected habits listed above (praise or conflict): _____

DAY-TO-DAY LIFE: Offer relevant details to help **give a sense of the influences upon you** (**both support & stressors**). List pertinent events which impact you physically, mentally, emotionally, energetically? The source may be positive, negative, historical, current, personal, professional. Describe briefly (one-word summary will suffice)_____
_____
Your **HOME** situation / dynamics / relationships: live alone, family, partner, kids, parents, pets, names, interests, ages, etc. _____
_____
_____
Your **WORK** situation / dynamics / relationships: key projects, aspects, people, associates, environment, etc. _____
_____
_____
USUAL SLEEP PATTERNS ___to___ hours per night. **SLEEP QUALITY** ❒ Solid ❒ Interrupted _____
Preferred Sleep Position: ❒ Back ❒ Front ❒ Right Side ❒Left Side ❒ALL Sides _____
Do you currently experience any mattress or pillow issues or concerns? _____
_____
Do you have any difficulty or discomfort lying in a certain position (this is also related to being on the massage table)?_____
_____
Do you sit for long hours? Details _____
SELF CARE This is to identify **current self support & and stressors upon your body.** Please list / describe.
Activities / Interests / Hobbies _____
Inactivity_____
Restorative Activities_____
Exercise Programs_____
Sports_____

YOUR HEALTH CARE TEAM: Are you receiving treatment from other health care professional? ❒ No. If ❒Yes, *please identify **condition** being treated and share **treatment effectiveness** for you:*

❒Massage Therapy ❒Craniosacral Therapy ❒Chiropractic ❒Physiotherapy ❒Psychologist/Coach ❒Naturopathy ❒Herbology ❒Homeopathy ❒Acupuncture ❒Needling (IMS) ❒Other:

❒High Blood Pressure ❒Low Blood Pressure ❒Heart Disease ❒Cancer ❒Kidney Disease ❒Diabetes ❒Epilepsy ❒Allergies ❒Circulation Problems ❒Skin Disorders ❒Headaches, Type_____ ❒Arthritis ❒Low Back Pain ❒Mid Back Pain ❒Neck Pain ❒Shoulder Pain ❒Pregnant due date: _____ ❒Concussion ❒Tailbone Trauma ❒Orthotics ❒System Issues in: ❒Blood, ❒Bones, ❒Skin ❒Organs ❒Other

❒Dental History: braces, implants, root canals, trauma, etc.

1. **CONSENT TO TREATMENT**: I hereby *consent to Jola May, Registered Massage Therapist (the RMT) to treat me* for the above noted purposes including such assessments, examinations and techniques which may be recommended by *the RMT.*
2. **I RELEASE** *the RMT from any & all liability from problems arising from the treatment as a result of information not given, or incorrectly given in this intake form.*
3. **MASSAGE THERAPY:** I acknowledge that *the RMT: a) is not a physician* and does not diagnose illness or disease or any other physical or mental disorder, yet may offer "Clinical Impressions" related to Massage Therapy scope of practice. b) I clearly understand that massage therapy is not a substitute for a medical examination. By continuing with treatment, I accept & assume the **risks of massage therapy** (explained by *the RMT* upon my request).
4. **MY MEDICAL CONDITION(s) - KEEP THE RMT CURRENT:** I acknowledge and understand that *the RMT must be fully aware of my existing or recent medical conditions.* Within this intake form, I have disclosed all medical conditions affecting me and the information is true and complete to the best of my knowledge. It is my responsibility to keep *the RMT* updated on my medical state. I authorize *the RMT to **RELEASE/OBTAIN INFORMATION** pertaining to my condition(s) and/or treatment* to/from my other caregivers or 3rd-party billing company.
5. **APPOINTMENT CANCELLATION, rescheduling, changes:** *48-hour notice is preferred. 24-hour notice is required;* otherwise client is responsible to pay either the late cancellation fee ($60) or the *full fee* equivalent to the session time booked — at the discretion of *the RMT*.
6. **PAYMENT** for each session is to be made at the time of the appointment.
7. **I HAVE READ ABOVE STATEMENTS** 1 through 6 and by **signing** this form, *I confirm my consent to treatment from Jola May RMT.*
   I understand that *at any time I may withdraw my consent* and treatment will be stopped.

Date: M:_____D:_____ Y: _____ **Signature:** _____