Healing Cedar Wellness Registered Massage Therapy Initial Intake

To assist in providing you with the best possible care, please fill out this form as accurately as you can. All the information provided will be kept confidential in your patient file.

Today's Date: ________________________

*** If you have currently an open WCB claim, we cannot treat you at this time ***

Do you currently have an open WCB or ICBC claim? Yes ______ No _______

Last Name: ______________________________ **First Name:** ___________________________________

Date of birth:_______________________Address:____

City:____Postal Code:________________________________

Phone: (H)________________ (W) ____________________ Email: _______________________________

Sex: Female ___Male ___ Transgender ___ Occupation:____

Medical Doctor's name: _________________MD's Phone number: ____________________________________

Whom may we thank for your referral? ____

Reason for today's visit:____

How long has this condition existed? _________ Known allergies:______________________________________

Please, list prescription and over the counter medication you are currently taking:

Muscle relaxant _________________________ Over the counter pain reducers _________________________

Sleeping pills ___________________________ Anti-inflammatory (NSAID)____________________________

Anxiety/depression _______________________ Beta Blockers ______________________________________

Prescription medications ____________________________ Others __________________________________

Please list any supplement or herbal medicines you are currently taking:

____

Past Surgery, Accident, any relevant medical history ____

____

Please indicate the following health care practitioner from which you are currently receiving treatment:

Massage therapist____ Acupuncturist ____ Chiropractor ____ Naturopath ____ Physiotherapist ____MD ________

Are you pregnant? _________ What is your due date _______________ Do you eat a balanced diet? ____________

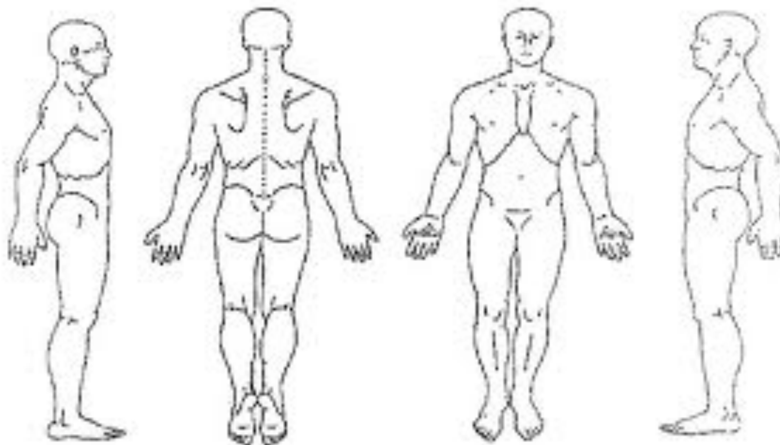
Is your sleep restful? _______ How many hours of sleep do you get per night? _____________________________

Stress level: Low - Med - High Energy level: Low-Med-High Activity/exercises_________________________

Do you have (or have had) any of the conditions below? Please check where applicable

Osteoarthritis		Blurred vision		Painful/difficult urination		Anemia	
Rheumatoid Arthritis		Dizziness/Vertigo		Inguinal hernia		Bruise easily	
Artificial rods, pins, plates, implants		Contact lenses		Colitis/Crohn's		Hemophilia	
Disc problems		Tooth/Jaw pain		Liver disease		Blood clots	
Osteoporosis/osteopenia		Ear pain		Heart attack		Varicose veins	
Fracture/dislocation		Ulcers		High/Low Blood pressure		Asthma	
Scoliosis		IBS		Stroke/Aneurysm		Bronchitis	
Headache		Nausea		Pacemaker		Pneumonia	
Head injury		Phlebitis		Diarrhea/constipation		Emphysema	
Skin conditions		Acne		Multiple Sclerosis		Pregnancy	
Impaired sensation		Diabetes		Mental illness		Menopause	
Fungal infection		Lupus		Hypo/Hyper Thyroid		Menstruating	
Epilepsy/seizures		Tumor/lump		Anxiety/depression		Breast pain	
Hepatitis		Herpes		HIV		Birth Control	

On the figures below please circle the areas of pain/concern:



Patient Consent Form

Please read this information carefully, and ask your massage therapist if there is anything that you do not understand. By signing below I authorize collection, use and disclosure of personal information as defined in the Personal Information and Privacy Act (PIPA).

Statement of Consent:

I confirm that I have read and understood the above information, and I consent to having treatments and procedures from your RMT at Healing Cedar Wellness. I understand that I can refuse treatment at any time. I wish to rely on the massage therapist treating me, to exercise judgment during the course of treatment which, based upon the facts then known, is in my best interests. I understand that all my records will be kept confidential and will not be released without my written consent. By voluntarily signing below I show that I have read this consent to treatment, and have had an opportunity to ask questions. I intend this consent form to cover the entire course of treatment for my present condition and further conditions for which I seek treatment.

I give consent to all practitioners at Healing Cedar Wellness to read, share and discuss my personal medical history while I am a patient at Healing Cedar Wellness.

I am aware that a missed or cancelled appointment without a 24 hours notice, will result in a charge for the full appointment amount. Receipt will indicate missed appointment fee.

Any questions regarding my appointments have been addressed. I have read this statement and fully understand it.

Print Name: ____________________________________ Date:___________________________

Signature:______________________________________ RMT initials: ___________________