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 and completely as you can.

Today's Date: _____

Do you have an open ICBC or WCB* Claim? ☐ Yes ☐ No

*If you have an open WCB Claim we may not be able to treat you at this time.

Last Name: _____ **First Name:** _____

Date of Birth: _____ Sex: _____ Occupation: _____

Address: _____ City: _____

Province: _____ Postal Code: _____ Email: _____

Phone Number (check preferred): ☐ (h) _____ ☐ (c) _____

Medical Doctor's Name: _____ MD's Phone Number: _____

How did you hear about Healing Cedar Wellness? _____

Reason for today's visit: _____

How long has this condition existed? _____ Known allergies: _____

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

Muscle relaxant: _____ Over the counter pain reducer: _____

Sleeping pills: _____ Anti-inflammatory (NSAID): _____

Anti-depressant/anxiety: _____ Beta Blockers: _____

Other: _____

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

_____

Past surgeries, accidents, major illnesses: _____

_____

Are you receiving treatment from any of the following health care practitioners?

☐ Massage Therapist ☐ Chiropractor ☐ Physiotherapist ☐ Osteopath

☐ Acupuncturist ☐ Naturopathic Doctor ☐ Medical Doctor ☐ Other _____

Are you pregnant? ☐ Yes ☐ No ☐ Maybe Due Date: _____

Sleep: □ Restful □ Restless □ Insomnia _____ hours/night

Stress Level: □ Low □ Medium □ High Energy Level: □ Low □ Medium □ High

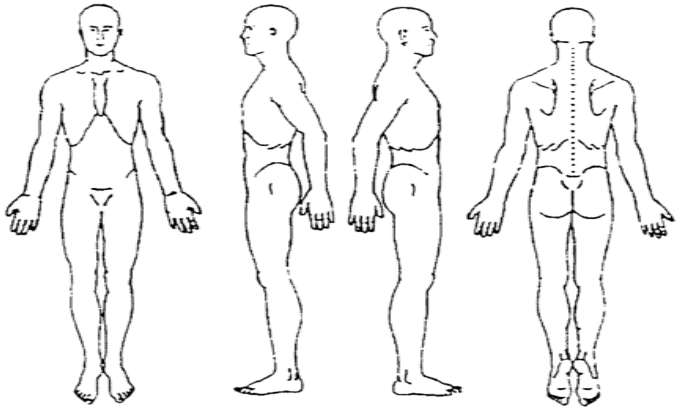
Activity/Exercise: _____

Do any of the following conditions listed below apply to you?

Mark with 'C' for current Mark with 'P' for past Circle if necessary

	Osteoarthritis		Dizziness/Vertigo		Blood Clots		HIV
	Rheumatoid Arthritis		Blurred Vision		High/Low Blood Pressure		Cancer
	Other Arthritis		Nausea		Pacemaker		Tumor/Lump
	Rods/Pins/Plates/Implants		Ear Pain		Varicose Veins		Anxiety/Depression
	Fracture/Dislocation		Tooth /Jaw Pain		Bruise Easily		Mental Illness
	Scoliosis		Skin Condition		Anemia		Breast Pain
	Disc Problems		Fungal Infection		Hemophilia		Pregnancy
	Osteopenia/Osteoporosis		Herpes		Hypo/Hyper Thyroid		Contact Lenses
	Headache/Migraine		Liver Disease		Diabetes		Contagious Condition:
	Head Injury		Hepatitis		Asthma		
	Spinal Injury		Kidney Disease		Bronchitis/Pneumonia		Other:
	Epilepsy/Seizures		Urinary Condition		Emphysema		
	Multiple Sclerosis		Heart Attack		IBS/Crohn's/Colitis		
	Impaired Sensation		Stroke/Aneurysm		Diarrhea/Constipation		

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



HEALING CEDAR WELLNESS

CONSENT TO MASSAGE THERAPY & RECORD SHARING

- Please read the following information carefully and ask your registered massage therapist (RMT) any questions about this form or its contents **BEFORE** you sign this document.
- Ask questions about your treatment **ANYTIME.**
- **IMMEDIATELY** advise your RMT if you become uncomfortable in any way with your treatment.

Massage Therapy: Is the health profession in which a person provides services for the purpose of developing, maintaining, rehabilitating or augmenting physical function, relieving pain or promoting health. It involves assessment of soft tissues and joints of the body and treatment and prevention of physical dysfunction, injury, pain and disorders of soft tissue and joints by manipulation, mobilization and other manual methods.

The Treatment: Initial and subsequent treatments may include the following: interview, assessment, development of a treatment plan, treatment involving hands on manipulation and mobilization, the use of heat or cold, recommendations for home care, and the use of oil and/or lotion.

I authorized the RMT to utilize the following modalities during my treatment(s), if appropriate:

☐ soft tissue mobilization ☐ joint mobilization ☐ exercise therapy (eg. stretching)
☐ heating pads / hot compress ☐ ice packs / cold compress ☐ other _____

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 and as such I have disclosed 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 condition that develops after my completion of this form.
___ The information disclosed by me is true and complete to the best of my knowledge.

Risks, Complications & Side Effects My initials indicate that I understand that:

___ There are risks associated with massage therapy. Examples include: bruising, aching, discomfort, short term aggravation of symptoms, and skin irritation.
___ My RMT will discuss with me the nature and purpose of the proposed treatment(s), the possible alternative methods of treatment(s), the risks involved and possible side effects.
___ If I develop a concern after signing I agree to discuss the same with the RMT immediately.
___ I can refuse/stop treatment at any time.

Sharing of My Patient Record My initials confirm that:

___ I give consent to all health care practitioners at Healing Cedar Wellness (HCW) who provide me treatment to read, share and discuss my medical history and treatments received while I am a patient at HCW, if appropriate. I understand this will enable HCW to maintain a complete patient record on my behalf.
___ I understand I may revoke this permission in writing at any time in the future.
___ I understand that my massage therapy patient record will remain under the custody and control of HCW unless I request or authorize, in writing, otherwise.

CONSENT TO MASSAGE THERAPY & RECORD SHARING continued.

___ **Confidentiality** My initials indicate that I am aware that the contents of this form and that my patient records will be kept confidential unless I have consented to the release of my information or where there is a legal requirement to provide my information to at third party. Further, I authorize collection, use and disclosure of personal information as defined in the Personal Information and Privacy Act (PIPA).

___ **Cancellation Policy** My initials indicate that I am aware that a missed or cancelled appointment without 24 hours notice will result in a charge for the full appointment amount and that the receipt will indicate a missed appointment fee.

By voluntarily signing below I confirm that: I have read and understood the above information, understand what to expect from today's treatment, have had an opportunity to ask questions, and that my questions have been addressed. I intend this consent form to cover the entire course of treatment for my present condition and further conditions for which I seek massage therapy treatment at HCW. I wish to rely on the RMT treating me to exercise judgment during the course of the treatment which, based upon the facts, then known, will be conducted in my best interest.

Name (please print): _____ Date: _____

Signature : _____ **(Do not sign until you have met with your RMT)**

Witness : _____

You may request a copy of this consent form at any time.