



Patient Intake Form

Name: _____ Date: _____
 Address: _____ Email: _____
 Tel: _____ Tel: (other) _____ Date of birth: _____
 Occupation: _____ How did you find us? _____
 Main interest for today's visit? Chiropractic Massage Orthotics Acupuncture Compression Stockings
 Reason for seeking treatment: _____ Is this your first massage or chiropractic treatment? Yes No
 Did a health care professional refer you for treatment? Yes No _____

<p><u>Cardiovascular</u></p> <p><input type="checkbox"/> High blood pressure <input type="checkbox"/> Low blood pressure <input type="checkbox"/> Chronic congestive heart failure <input type="checkbox"/> Heart attack <input type="checkbox"/> Phlebitis/varicose veins <input type="checkbox"/> Stroke/CVA <input type="checkbox"/> Pacemaker or similar device <input type="checkbox"/> Heart disease</p> <p>Is there a family history of any of the above? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p><u>Respiratory</u></p> <p><input type="checkbox"/> Chronic cough <input type="checkbox"/> Shortness of breath <input type="checkbox"/> Bronchitis <input type="checkbox"/> Asthma <input type="checkbox"/> Emphysema</p> <p>Is there a family history of any of the above? <input type="checkbox"/> Yes <input type="checkbox"/> No</p>	<p><u>Infections</u></p> <p><input type="checkbox"/> Hepatitis <input type="checkbox"/> Skin conditions <input type="checkbox"/> TB <input type="checkbox"/> HIV <input type="checkbox"/> Herpes</p> <p><u>Other Conditions</u></p> <p><input type="checkbox"/> Loss of sensation, where? _____ _____ <input type="checkbox"/> Diabetes, type? _____ <input type="checkbox"/> Allergies/hypersensitivity, to what? _____ Type of reaction: _____ <input type="checkbox"/> Epilepsy <input type="checkbox"/> Cancer, where? _____ _____ <input type="checkbox"/> Skin conditions, what? _____ _____ <input type="checkbox"/> Arthritis</p> <p>Is there a family history of arthritis? <input type="checkbox"/> Yes <input type="checkbox"/> No</p>	<p><u>Head/Neck</u></p> <p><input type="checkbox"/> History of headache <input type="checkbox"/> History of migraines <input type="checkbox"/> Vision problems <input type="checkbox"/> Vision loss <input type="checkbox"/> Ear problems <input type="checkbox"/> Hearing loss</p> <p><u>Women</u></p> <p><input type="checkbox"/> Pregnant, due: _____ <input type="checkbox"/> Gynecological conditions, what? _____</p> <p><u>Substance Use</u></p> <p>Cigarette use? <input type="checkbox"/> Never <input type="checkbox"/> Previously <input type="checkbox"/> Currently How long? _____ Quit date? _____ Alcohol use (drinks/week): _____</p> <p><u>Lifestyle</u></p> <p>Typical diet? _____ Exercise/frequency: _____ Sleep (hours/night): _____ Sleep position? <input type="checkbox"/> Front <input type="checkbox"/> Side <input type="checkbox"/> Back</p>
<p>Current Medications: _____ _____ Condition it treats: _____ _____ Are you currently receiving treatment from another health care professional? If yes for what? _____ _____ Surgery, date: _____ Nature: _____ Injury, date: _____ Nature: _____</p>		<p>Do you have any other medical conditions? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, what? _____ Do you have any internal pins, wires, artificial joints or special equipment? <input type="checkbox"/> Yes <input type="checkbox"/> No What? _____ Where? _____ How would you describe your overall health? _____ Primary Physician: _____ Contact details: _____</p>



Current Symptoms

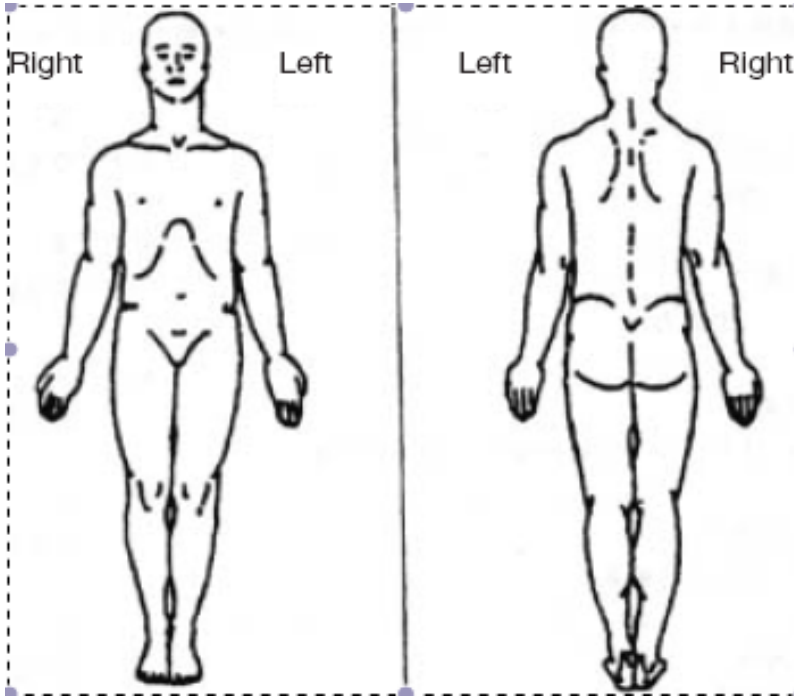
Please rate your pain intensity: 10 9 8 7 6 5 4 3 2 1 0 (0 = no pain)

When did it start? _____ How? _____

Is it getting **better, worse** or **staying the same**? _____

Is it worse in the morning/ daytime/ evening? _____

Indicate with an **X** on the diagram below, the location of your pain.



Describe the character of your pain (*check all that apply*):

- Dull/achy
- Stiff/tight
- Sharp/stabbing
- Numbness/tingling
- Burning
- Catching
- Other: _____

What makes it worse?

What makes it better?

Notes (*Internal Use*): _____



Privacy Code and Informed Consent: Registered Massage Therapy

Personal Information

Personal information is information about an identifiable individual. Generally, the information we collect is limited to name, home contact information, gender and age. As part of your patient file, we retain your health history, health measurements and examinations results, health conditions, assessment results and diagnosis, the health services provide to you or received by you, your prognosis and other opinions formed, compliance with treatment and the reasons for your discharge and discharge recommendations. We may also maintain records for payment and billing purposes. Only necessary information is collected about you. We only share your information with your consent, the use, retention and destruction of your personal information complies with existing legislation and privacy protection protocols. Privacy protocols comply with privacy legislation, standards of our regulatory body, the College of Registered Massage Therapists of Ontario and the law.

Disclosure of Personal Information

Our clinic understands the importance of protecting your personal information. To help you understand how we are doing that, we outline below how the clinic will use and disclose information.

- To deliver safe and effective patient care
- To enable use to contact you
- To communicate with other health care providers
- To complete and submit claims on your behalf to third party players
- To comply with legal regulatory requirements under the Massage Therapy Act and the Regulated Health Professions Act
- To process payments and collect unpaid amounts

Informed Consent

I hereby request and consent to the service of massage therapy treatment and other massage procedures, including various modes of remedial exercise and hydrotherapy, on me by the registered massage therapist.

I understand that I will have an opportunity to discuss with the massage therapists and/or with other office or clinic personnel, the nature of massage therapy treatment and other procedures.

I understand the results may not be guaranteed.

I am informed that, as in all health care, in the practice of massage therapy there are some very slight risks to treatment, including, but not limited to, muscle strains and sprains, bruising, light headed or dizziness, and tenderness.

I do not expect the massage therapist to be able to anticipate and explain all risks and complications and I wish to rely on the massage therapist to exercise judgment during the course of the treatment which the massage therapist feels at the time, based upon the facts then known, and is in my best interests.

I understand that I will be draped at all times and the areas undraped will be secure to insure there is no indecent exposure. If undraping my gluteals is significant in the treatment I do understand that it is part of the therapy.

I am informed that I have the right to terminate the treatment at any time, and the right to alter the therapist's pressure during the massage treatment.

I have read the above consent. I have also had an opportunity to ask questions about its consent, and by signing below, I agree to the above named procedures. I intend this consent form to cover the entire course of the treatment for my present condition and for any future condition(s) for which I seek treatment.

Client name: _____ Date: _____

Client signature: _____ Therapist signature: _____



CREDIT CARD AUTHORIZATION AND CONSENT FORM

I _____ hereby authorize Chiropractic and Massage in the Village to charge my credit card due to an outstanding payment, not having any Extended Health Insurance Coverage, Missed Appointment and/or Late Cancellations made in **less than 24 hours** of the appointment time. A team member from Chiropractic and Massage in the Village will contact me at the time of the transaction, to make me aware of any charges made.

PLEASE BE AWARE:

LATE CANCELLATIONS AND MISSED APPOINTMENTS WILL BE CHARGED FULL TREATMENT AMOUNTS

Type of Card: MasterCard Visa (NO Debit Visa Allowed)

Credit Card Number: _____

Expiration Date: _____

CVV: _____

Name of Cardholder: _____

Authorized Signature of Cardholder: _____

By signing this form, I acknowledge the charges described hereon and assume full responsibility for said charges and agree to honor and abide by the terms of payment. I acknowledge and accept Chiropractic and Massage in the Village Terms and Conditions.

Client Signature: _____

Date: _____