Sarah Taylor, RMT - Client Health History Intake Form

Name _____ **Date of Birth (YYYY/MM/DD)** _____

Address _____

City _____ **Province** _____ **Postal Code** _____

Home # _____

Cell # _____

Email address _____

Occupation _____

Employer _____

Physician _____

Emergency Contact _____

Phone _____ **Relationship** _____

Have you had a massage before? Yes / No

Date of Last Visit _____

What pressure do you generally prefer when receiving a massage? Light / Moderate / Deep

(If you are unsure, please discuss with RMT)

Primary Reason for your Appointment Today _____

_____

_____

How did you hear about us?

_____

Insurance Coverage PRIMARY Provider:

_____

Plan / Contract / Group # _____

Certificate / ID # _____

Policy Holder's Name _____

Policy Holder's DOB (YYYY/MM/DD) _____

Insurance Coverage SECONDARY Provider:

_____

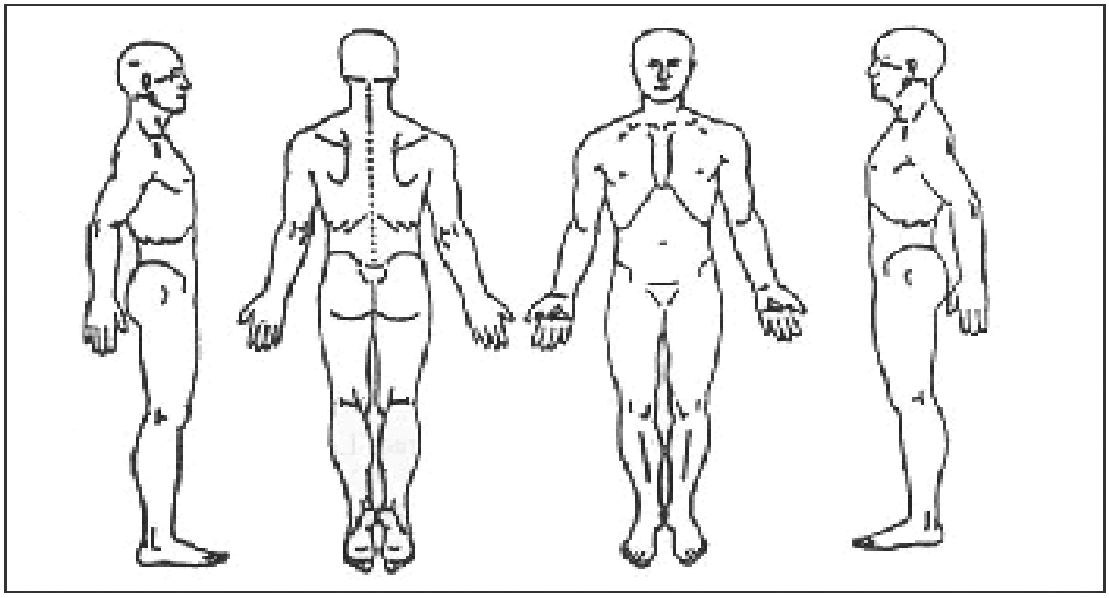
Plan / Contract / Group # _____

Certificate / ID # _____

Policy Holder's Name _____

Policy Holder's DOB (YYYY/MM/DD) _____

Please indicate affected areas:



Please check off any of the following health conditions that apply to you:

□ Heart Problems
□ High / Low Blood Pressure
□ Varicose Veins
□ Blood Clotting Disorder
□ Bruise easily
□ Cancer
□ Fibromyalgia
□ Vision or Hearing Disturbances
□ Low / Mid Back Pain
□ Shoulder / Neck Pain
□ Frequent headaches OR Migraines
□ Dizziness / Vertigo / Tinnitus
□ Arthritis
□ Osteoporosis
□ HIV/ AIDS
□ Diabetes
□ Kidney Disease
□ Epilepsy / Seizures
□ Circulation Problems
□ Numbness or Tingling
□ Nervous System Disorder
□ Anxiety
□ Depression
□ Skin Disorders / Sensitive Skin / Eczema / Rashes
□ Asthma
□ Digestive Problems

Please list any medications, vitamins or supplements that you are currently taking (prescribed or over the counter)____

_____

_____

Please List any Allergies you have _____

Have you had any surgeries, injuries or trauma in the past 5 years? Yes / No **If yes, please explain**_____

_____

_____

List any medical implants (cardiac pacemaker, pins, etc.) _____

Do you have ANY OTHER medical conditions that I should be aware of? Yes / No **If yes, please explain:**_____

_____

WOMEN:
Are you pregnant? Yes / No **If YES, How far along?**_____**Taking Birth Control:** Yes / No **Menopausal?** Yes / No

Do you exercise? Yes / No **What activities / How many days per week?**_____

_____

_____

Rate your stress levels on a scale of 1 to 10 (1 being the best – 10 being the worst)**:**

Work: _____ **/ 10** **Home:** _____ **/ 10**

Do you wake rested? Yes / No **How many hours of sleep is normal for you:**_____

Sleeping position that is normal for you: (circle) Back Stomach Left Side Right Side

Do you have difficulty laying on your back? Yes / No **On your stomach?** Yes / No

What is the percentage of your day spent: Sitting?_____ **Standing?**_____

INFORMED CONSENT TO MASSAGE THERAPY TREATMENT

I hereby consent to my Massage Therapist to treat me with massage therapy for the above noted purposes including such assessments, examinations and techniques, which may be recommended by my Therapist. I am aware of the purposes of massage therapy, and should any concerns arise at any time I will not hesitate to discuss them with my massage therapist.

I acknowledge that the Massage Therapist is not a physician and does not diagnose illness or disease or any other physical or mental disorder. I clearly understand that massage therapy is not a substitute for a medical examination. It is recommended that I attend my personal physician for any ailment that I may be experiencing. I acknowledge that no assurance or guarantee has been provided to me as to the results of the treatment.

I acknowledge that with any treatment there can be risks and those risks have been explained to me and I assume those risks. I acknowledge and understand that the Massage Therapist must be fully aware of my existing medical conditions. I have completed my medical history form as provided by my Massage Therapist and disclosed all of those medical conditions affecting me. I have given my therapist valid information regarding my health condition, to the best of my knowledge, and will not hold them responsible for further complications herein. It is my responsibility to keep the Massage Therapist updated on my medical history. The information I have provided is true and complete to the best of my knowledge. I authorize my Massage Therapist to release or obtain information pertaining to my condition(s) and/or treatment to/from my other caregivers or third party payers.

I have read the above noted consent and I have had the opportunity to question the contents and my therapy. By signing this form, I confirm my consent to treatment and intend this consent to cover the treatment discussed with me and such additional treatment as proposed by my Massage Therapist from time to time, to deal with my physical conditions for which I have sought treatment. I understand that at any time I may withdraw my consent and treatment will be stopped.

***** CANCELLATION POLICY*****

24 HOUR NOTICE IS REQUIRED WHEN CANCELLING AN APPOINTMENT.

FAILURE TO DO SO WILL REQUIRE FULL PAYMENT OF MISSED APPOINTMENT
NO-SHOWS WILL BE EXPECTED TO PAY FULL PAYMENT.

ARRIVING LATE FOR YOUR APPOINTMENT WILL RESULT IN FULL PAYMENT

PLEASE REMEMBER THAT THIS TIME HAS BEEN SET ASIDE SPECIFICALLY FOR YOU!

CLIENT NAME _____ **CLIENT SIGNATURE** _____

DATE _____

GUARDIAN NAME_____ **GUARDIAN SIGNATURE** _____
(If Client is under 18 years of age)

RMT SIGNATURE _____