Back to Back Massage Therapy Intake Form

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CONSENT to TREATMENT & RECORD SHARING

Patient name: _____ DOB: (dd/mm/yy): ____/____/____

- **Please read this document, including Schedule A (on page 4), carefully and completely. It is important.**
- Ask your RMT any questions you have about this form or its contents BEFORE you sign this document.
- Ask questions about your treatment at ANYTIME.
- Immediately advise your RMT if you become uncomfortable in any way with your treatment.

The Treatment: I authorize and consent to the RMT performing the following treatments on me:
Soft Tissue Mobilization: _____ Joint Mobilization: _____Exercise Therapy/homecare: _____
Trigger Point Therapy: _____ Hydrotherapy Hot/Cold: ___Myofascial Release Technique: ____
(IASTM: Instrument assisted soft tissue manipulation):_____ Other: _____

Risks, Complications and Side Effects: **my initials indicate that I acknowledge and understand that:**

_ There are risks associated with Massage Therapy. Examples include: bruising, aching, discomfort, short term aggravation of symptoms and skin irritation.
_ My RMT has discussed with me the nature of purpose of the proposed treatments, the possible alternative methods of treatment, the risks involved and the possible complications and side effects.
_ I have discussed my concerns about possible risks with my therapist BEFORE signing this document. If I develop a concern after signing, I agree to discuss the same with the RMT immediately.

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.
_ I have disclosed to the RMT 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 such condition that may develop after my completion of this form.
_ The information disclosed by me is true and complete to the best of my knowledge.
_ Sharing of My Patient Record: My initials confirm that I request and authorize my RMT to provide to the clinic and to other health care practitioners who provide me with treatment, copies of any patient record created by my RMT. I understand that I may revoke this permission in writing at any time in the future.

Confidentiality: The contents of this form and my patient records will be kept confidential unless I have expressly or impliedly consented to the release of my information or where there is a legal requirement to provide my information to a third party.

No Guarantee of Results: I acknowledge and confirm that no guarantee or assurance of results has been made to me regarding my treatments.

_____ _____

Patient Signature* **Date**: (dd/mm/yy)

(*in the case of a person incapable of providing consent, signature of Parent or Guardian, in which case the name & Relationship of person signing: _____)

Patient Basic Information:

Address:_____ Birth Date:_____ Care Card:_____

_____ Occupation:_____

Home Phone:_____ Emergency Contact:_____

Work Phone:_____ Cell Phone:_____

Medical Doctor:_____ Email: _____

Please check the type of reminder you would like: Text ☐ (Cell phone provider :_____) Email ☐

PLEASE LIST ALL ALLERGIES: _____

1. **Reason for seeking care/major complaint(s):**

   1) _____

   2) _____

   3) _____

2. **Onset of pain**: ◯ Sudden ◯ Gradual ◯ Injury Cause of Injury: _____

3. **On a scale of 1-10 (0 being <u>no pain</u> to 10 being <u>unbearable pain</u>):**

How would you rate your pain today? _____ How would you rate your pain on average? _____

4. **What aggravates the pain?** _____

5. **What relieves the pain?** _____

6. **Has this condition occurred before?** ◯ No ◉ Yes If yes, how so? _____

7. **How does the pain affect your daily routine?** _____

_____

8. **Please list all medications you are currently taking:** _____

_____

9. **Are you currently seeing any other practitioners?**

   ☐ R.M.T. ☐ Physiotherapist ☐ Chiropractor ☐ Acupuncturist ☐ Other _____

10. **Please list <u>ANY</u> accidents, illnesses, or other injuries:** _____

_____

11. **Do you have/wear:** ☐ Implants ☐ Steel Pins ☐ Foot Supports ☐ Glasses/Contact Lenses

    Other: _____

12. **Are you satisfied with your:**

Overall Health:	◯ No ◯ Yes	Ability to Relax:	◯ No ◯ Yes	Sleep:	◯ No ◯ Yes
Energy Level:	◯ No ◯ Yes	Fitness Level:	◯ No ◯ Yes	Diet:	◯ No ◯ Yes

13. Medical History - Please mark all that apply to you:

☐ Allergies	☐ Fractures	☐ Insomnia
☐ Arthritis	☐ Head Injuries	☐ Jaw Pain
☐ Cancer	☐ Headaches	☐ Respiratory Issues
☐ Circulatory Condition	☐ Heart Condition	☐ Seizures
☐ Contagious Condition	☐ Hepatitis A/B/C	☐ Skin Condition
☐ Diabetes	☐ High/Low Blood Pressure	☐ Spinal Injury
☐ Dislocation	☐ HIV/AIDS	☐ Sprains/Strains
☐ Fainting	☐ Infection	☐ Stroke

☐ Pregnant: _____ Or trying to conceive? _____

☐ Please list any pregnancy complications you have or have had? _____

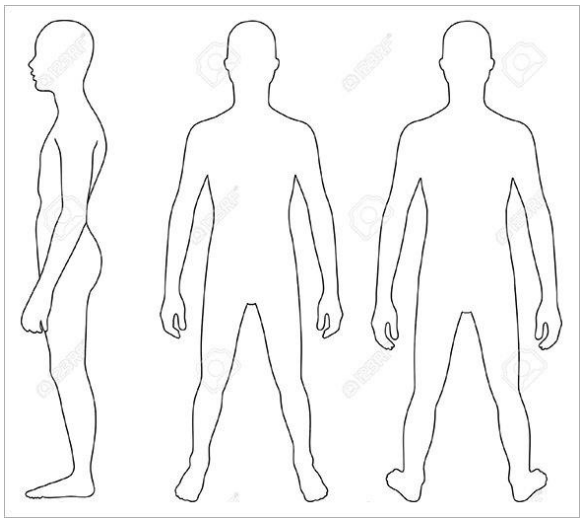
☐ Other: _____

Schedule A
To consent to Treatment of

Patient Name:_____ Date: ____/____/____

Body Areas to be treated:

I acknowledge and confirm that the areas of my body circled on the diagram below may be touched by the RMT during the course of my treatments: (TO BE DONE WITH THERAPIST DURING VISIT)



I acknowledge and confirm that it may be necessary for the RMT to adjust their treatment plan during my treatment, in which case they will discuss that with me.

Patient signature*: _____ Date: ____/____/____

(*in the case of a person incapable of providing consent, signature of Parent or Guardian, in which case the Name and Relationship of the person signing: _____)