Massage Intake Form

Full Name:	Date:	
Contact No:	Age:	
Address:	City:	Postal Code:
Date of Birth: (DD/MM/YY)	Male/Female	Email:
Employer:	Occupation:	
Extended health Insurance Provider:		
Family Doctor Name	Number:	
Date of last Doctor Visit:	Reason:	
Is your condition due to: Car Accident	Workplace Injury?	Personal Injury?
Date of Injury	Any Medications?	
Are you currently seeing any other practitioners for your injury?		
Any previous surgeries or relevant medical history:		
Womens Health: Are you currently pregnant?		
Blood Pressure:		
Have you ever seen? Chiropractic Massage Therapy	Physiotherapy Shockwave	Acupuncture
How did you hear about this clinic?		
Emergency contact name:	Phone number:	

Privacy Policy: Personal health information is collected at Managed at Inklein Health Klinic in accordance with the Personal Health Information Protection Act (PHIPA). For more information please ask your health care provider or go to www.ipc.on.ca

- I hereby confirm that all information I have supplied is accurate and complete.
- I consent to receiving Registered Massage Therapy from Inklein Health Klinic.

Signature _____

Date: _____

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Please X the box for any conditions or symptoms presently causing you problems. Please check the box for those conditions or symptoms that you have had in the past

General Symptoms
- ☐ Loss of consciousness
- ☐ Blackouts
- ☐ Headaches
- ☐ Fever
- ☐ Excess sweating
- ☐ Night Sweats
- ☐ Loss of weight
- ☐ Night pain
- ☐ Generalized pain
- ☐ Nervousness
- ☐ Convulsion
- ☐ Loss of sleep

Neurologic
- ☐ Dizziness
- ☐ Fainting
- ☐ Problems speaking
- ☐ Problems swallowing
- ☐ Blurred vision
- ☐ Double vision
- ☐ nausea
- ☐ Clumsiness
- ☐ Numbness or tingling

Muscles and Joints
- ☐ Sore/stiff neck
- ☐ Mid back ache
- ☐ Low back ache
- ☐ Painful tailbone
- ☐ Shoulder pain
- ☐ Arm/forearm pain
- ☐ Elbow pain
- ☐ Wrist/hand pain
- ☐ Hip pain
- ☐ Knee pain
- ☐ Ankle/foot trouble
- ☐ Arthritis
- ☐ Loss of strength

Eyes/Ears/Nose/Throat
- ☐ Failing vision
- ☐ Eye pain
- ☐ Failing hearing
- ☐ Earache
- ☐ Ring/buzz in ears
- ☐ Frequent colds
- ☐ Sinus infection
- ☐ Enlarged Thyroid

Respiratory
- ☐ Asthma
- ☐ Chronic Cough
- ☐ Spitting of phlegm
- ☐ Splitting up blood
- ☐ Difficulty breathing

Cardiovascular
- ☐ Bleeding disorder
- ☐ High blood pressure
- ☐ Chest pain
- ☐ Stroke
- ☐ Hardening of arteries
- ☐ Varicose veins
- ☐ Swelling of ankles
- ☐ Poor circulation
- ☐ Heart/blood disease
- ☐ Angina

Genitourinary
- ☐ Trouble urinating
- ☐ Blood in urine
- ☐ Kidney infection
- ☐ Bedwetting
- ☐ Prostate trouble

GU for women
- ☐ Painful menstruation
- ☐ Excessive flow
- ☐ Hot flashes
- ☐ Irregular/absent cycle
- ☐ Cramping/backache
- ☐ Vaginal discharge
- ☐ Swollen breast
- ☐ Lump in breast

Currently are you on birth control pills/patch
yes no
Previously on birth control pills/ patch
yes no
# of pregnancies ____
# of children ____

Skin
- ☐ Rashes/itching
- ☐ Bruise easy
- ☐ Dryness
- ☐ Boils
- ☐ Hives (allergies)

Gastrointestinal
- ☐ Poor appetite
- ☐ Indigestion
- ☐ Excess hunger
- ☐ Belching or gas
- ☐ Vomiting
- ☐ Pain over stomach
- ☐ Constipation
- ☐ Diarrhea
- ☐ Hemorrhoids
- ☐ Jaundice
- ☐ Gall bladder trouble
- ☐ Intestinal worms
- ☐ Ulcer
- ☐ Diabetes

Have you ever had any fractures?
yes no
If yes – where?
Do you have a pacemaker?
yes no
Have you ever been in a car accident?
yes no
If yes – when? _____
Have you ever been hospitalized?
yes no
Why/When? _____
Are you currently a smoker?
yes no
How much? _____
Did you smoke previously?
yes no
How much? _____
Have you ever been diagnosed:
With cancer? yes no
With aids? yes no
with HIV? yes no

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Inklein Health Klinic Massage Therapy Policies and Procedures:

Thank you for choosing Registered Massage Therapy at Inklein Health Klinic. To ensure that you have the best experience possible, please take the time to read our clinic policies and procedures below.

- **Please be punctual for your massage therapy appointments**
- **We require at least 24 hours cancellation notice for your massage appointments. Clients will be charged for missed appointments**
- **Regulatory guidelines require your RMT to perform an assessment on the first visit to ensure a safe and appropriate treatment.**
- **Please take care getting on and off the massage table, and avoid leaning on the headrests as they can easily be damaged.**
- **Communication is very important during your treatment. Please be sure to discuss pressure and technique with your therapist – questions and feedback are always appreciated**
- **Some client may experience temporary "post massage" symptoms: including some soreness, and stiffness.**

By signing this form I confirm that I have read and understood the above and will comply with the above massage therapy policies and procedures:

Signature:_____
Date: _____

Fee Schedule

30 Minute massage: $60 plus HST $67.80
45 Minute massage: $80 plus HST $90.40
60 Minute massage: $100 plus HST $113.00
90 Minute massage: $145 plus HST $163.85

Cancellation Policy: In consideration of your fellow patients and your healthcare professional, a minimum of 24 hours notice is required to change or cancel your appointment.
Payment Policy: Once a treatment has been provide you become solely responsible for its payment which must be paid in full at the time of the service. We accept Visa, Mastercard, Debit, Cheque or Cash.
In the event that WSIB/Auto Insurance/ EHC benefits fail to pay for services rendered you will become fully responsible for payment.
Thank you for helping up maintain a high level of service for all our clients.

I have read and understood the above and agree to abide by these clinic policies

Signature: _____
Date: _____

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Consent for Assessment and Treatment

I _____ (patient/client) hereby give _____ (therapist) and his/her associates permission to provide massage therapy assessment and treatment according to our agreed upon therapeutic goals.

Benefits of massage therapy include: the decrease or elimination of pain, reduced soft-tissue tension and muscle spasm, increased range of motion and joint mobility, improved muscle performance, reduced swelling, improved circulation to tissues, improved body awareness and management of impairments related to several conditions and injuries affecting the body.

The **risk of adverse effects related to massage therapy** are very low, but include the potential of bruising, tenderness following treatment, injury to soft-tissues (muscles, nerves, connective tissues) or bones, and the aggravation of an existing problem.

I have been informed of the clinical indications; benefits, risks and potential side effects associated with the assessment ad treatment process as they relate to my personal therapeutic needs.

If the therapist believes there are clinical indications requiring the assessment and/or treatment involving physical contact to any of the body regions listed below, you will be asked to initial next to the indicated area to acknowledge your consent to do so.

_____ Buttock/gluteal region

_____ Upper inner thigh region

_____ Chest wall

_____ Intra-oral

_____ Breast

This consent agreement is valid for the duration of my treatment plan, and I am aware that **I can revoke my consent at any time**. This agreement does not relieve the therapist of his/her duty to obtain verbal consent (or continued written consent when required) at future appointments when no substantive changes in the plan of care have been made.

_____ _____

Signature of Patient Date

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Inklein Health Klinic is a multidisciplinary clinic, which offers a wide array of potential care for all of your health concerns. If you would like to find out more about what your personal health insurance covers, please let us know and our staff will call for you to find out.

Insurance Company: _____

Service	Coverage Amount	% Coverage	Max per Treatment	Dr. Note
Physiotherapy				
Acupuncture				
Chiropractic				
Naturopath				
Massage				
Psychotherapy				
Orthotics				
Compression Hosiery				

Year End: _____

Spousal Secondary Coverage? _____