

Be The Change Massage Therapy

Genevieve Poirier, RMT

Confidential Health Intake Form

Welcome! The information you give below will assist me in treating you safely. Feel free to ask any questions about the information being requested. Please note that all information being collected will be kept confidentially unless allowed or required by law. I will request your written permission before releasing any information.

Name: _____ Date of Birth: _____
 Phone Number: _____ Cell Phone: _____ Email: _____
 Address: _____ City: _____ Postal Code: _____
 Occupation: _____ Have you received Massage Therapy before? _____
 Were you referred? _____ By Whom? _____

Please indicate conditions you are experiencing with a \surd , and any you have experienced in the past with a X.

CARDIOVASCULAR

- high blood pressure
- low blood pressure
- chronic congestive heart failure
- heart attack
- phlebitis/varicose veins
- stroke/CVA
- pacemaker or similar device
- heart disease
- bypass surgery

Is there a family history of any of the above? Which?

RESPIRATORY

- chronic cough
- shortness of breath
- bronchitis
- asthma
- emphysema

Is there a family history of any of the above? Which?

INFECTIONS

- hepatitis
- TB
- HIV/AIDS
- herpes

REPRODUCTIVE

- Males:
- pelvic pain
 - prostate issues
- Females:
- menstrual/menopausal issues
 - pelvic pain
 - recent pregnancy

DIGESTIVE

- difficult digestion
- constipation/diarrhea
- Crohns/Colitis/Ulcers
- gallbladder/liver problems

HEAD/NECK AREA

- headaches/migraines
- vision loss/problems
- dental problems
- hearing loss/problems
- earaches

SKIN

- contagious skin disease
- sensitivities/allergies: to what?

 _____ reaction: _____
- rashes
- loss of sensation
- eczema/psoriasis
- bruise easily

OTHER CONDITIONS

- diabetes
- arthritis
- osteoporosis/bone disease
- degenerative disc disease
- fibromyalgia
- car accident (MVA)
- cancer
- epilepsy/seizures
- plantar warts
- Athlete's foot
- hemophilia

Is there a family history of any of the above? Which?

Please list any current medication, now and within the past 6 months:

Please list any supplements and herbal/natural/homeopathic remedies:

Have you had surgery? Please list dates and types.

Please list any accidents, injuries, and falls, and the dates.

Please check any of the following that apply to you.

- | | |
|--|--|
| <input type="checkbox"/> contact lenses/glasses | <input type="checkbox"/> regular exercise |
| <input type="checkbox"/> artificial joints/body parts | <input type="checkbox"/> sleep well |
| <input type="checkbox"/> hearing aids | <input type="checkbox"/> drink plenty of water |
| <input type="checkbox"/> special equipment | <input type="checkbox"/> good eating habits |
| <input type="checkbox"/> internal pins/plates/wires/screws | |

How do you feel about your general health? _____

Please explain the reason for your visit today. _____

For office use

Update: _____

Date: _____

Date: _____

Date: _____

Date: _____

Consent to Treatment

Welcome!

Please read the following points before signing this consent form.

Your treatment time includes a review of your health history, any assessments, and time to change.

Depending on any assessments, I may treat you while you are on your stomach, back, and/or side. I will provide pillows under the abdomen and legs to support your low back.

I will be working several muscular-skeletal structures, which I will name before each treatment. You will be covered by a blanket at all times, except the area I am working on. Your comfort is important- please feel free to undress to your level of comfort.

Some risks of treatment are that treatments may be deep or uncomfortable. I will check in with you during your treatment and apply pressure to your comfort level. It is possible to have aching the next day, however, if you follow the self care suggestions I provide, this is less likely. It is possible without treatment, your condition may worsen, improve, or stay the same. With treatments, your symptoms may decrease, and you may notice an increased range of motion. Depending on my findings, I may refer you for another type of therapy, such as physiotherapy or chiropractic. During your treatment, I may use stretches or hydrotherapy. At the end of your session, I will recommend a frequency of treatments specifically tailored to your needs, as well as a reassessment time to evaluate your progression.

Your comfort is most important- feel free to stop or modify the treatment at any time. If you would like the music adjusted, the room warmer/cooler, or the light dimmer, please let me know.

I have allotted this time for your care.

24 hours notice is required for cancellation.

If 24 hours are not provided, you will be billed for the time blocked off for you.

Do you consent to treatment? Yes No

Signature: _____ Date: _____



Be The Change Massage Therapy
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Appointment Cancellation Policy Agreement:

Be The Change Massage Therapy is committed to providing all our clients with exceptional care. When a client cancels without giving enough notice, they prevent another client from being seen.

Please call or text us at 613-330-5339 with a minimum of 24 hrs notice of your scheduled appointment to notify us of any changes or cancellations, even if your appointment falls on a Monday.

If less than 24 hrs notice is given, we consider this a “missed appointment”, and you will be charged a cancellation/missed appointment **fee of 75\$.**

Please sign below to consent to these terms

→ _____

Client's signature (Client's parent/guardian if under 16)