Carol Fellowes RMT Therapeutic Massage+Yoga

Patient Intake Form

Patient information contained within this form is considered strictly confidential.

Your responses are important for me to better understand the health issues you face and ensure the delivery of the best possible treatment.

Name: ____

Date: ____/_____/_____

Insurance: ______________________________

Date of Birth: (dd/mm/yr) ____/_______ /______

Address: ____________________________________

____

____

Phone #: home: ______________ work: _________________

E-mail address: ____________________________________

Occupation: _____________________ Employer: ________________________

Family Doctor:_________________________ ph#____________________

How would you rate your general health: ____

Please list any medication you are currently taking and why:

Give a brief detailed description of the problem you are currently experiencing:

____

____

How long have you had this condition?____

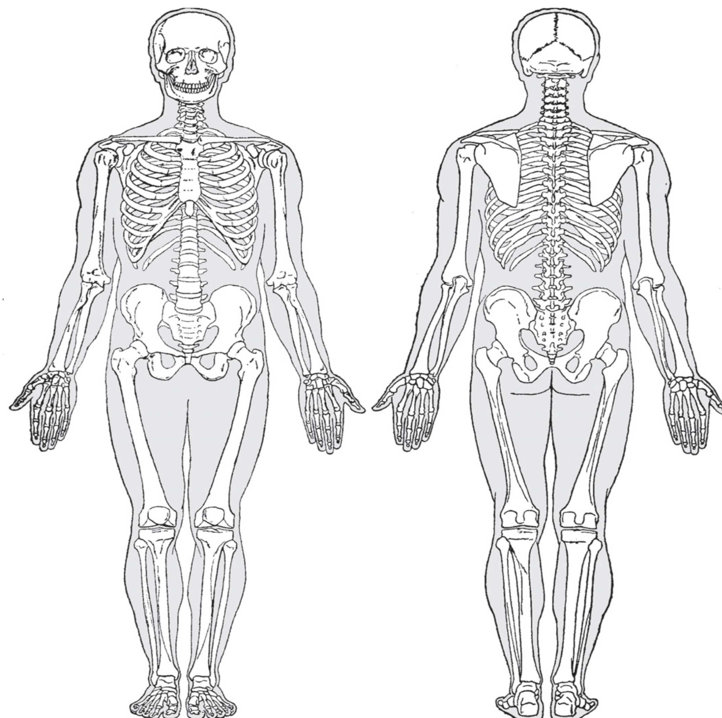
Is it getting worse? □ yes, □ no ___________________________

Does it bother you during (check appropriate box): □ work, □ sleep, □ other:__________________________________

What seemed to be the initial cause? ____

What would be your level of pain on a scale of 1-10 (1 being the least amount of pain, 10 being the most amount of pain) that you are experiencing now? 1__ 2__ 3__ 4__ 5__ 6__ 7__ 8__ 9__ 10__

On the diagram below, please show your areas of concern ↓



Health History

General ☐ Allergies ☐ Depression ☐ Dizziness ☐ Fainting ☐ Fatigue ☐ Fever ☐ Headaches ☐ Loss of sleep ☐ Mental illness ☐ Tremors ☐ Weight loss / gain	**Muscle / Joint** ☐ Arthritis / rheumatism ☐ Bursitis ☐ Foot trouble ☐ Muscle weakness ☐ Low back pain ☐ Neck pain ☐ Mid back pain ☐ Joint pain ☐ Broken bones ______________________ ______________________ ______________________	**Skin** ☐ Boils ☐ Bruise easily ☐ Dryness ☐ Hives or allergies ☐ Itching ☐ Rash ☐ Varicose veins ☐ Eczema	**Eye, Ear, Nose & Throat** ☐ Colds ☐ Deafness ☐ Ear ache ☐ Eye pain ☐ Nose bleeds ☐ Ringing of the ears ☐ Sinus infection ☐ Sore throat ☐ Tonsillitis ☐ Vision problems
Genitourinary ☐ Bladder infection ☐ Blood in urine ☐ Kidney infection ☐ Kidney stones ☐ Prostate trouble ☐ Stress incontinence Urination ☐ Overnight more than twice ☐ More than 8x in 24hrs ☐ Decreased flow/force ☐ Painful urination ☐ Urgency to urinate	**Gastrointestinal** ☐ Abdominal pain ☐ Colitis / Crohn's ☐ Constipation ☐ Diarrhea ☐ Diverticulitis ☐ Gallbladder trouble ☐ Hernia ☐ Hemorrhoids ☐ Jaundice ☐ Liver trouble ☐ Nausea ☐ Painful defecation ☐ Vomiting	**Cardiovascular** ☐ High blood pressure ☐ Low blood pressure ☐ Hardening of the arteries ☐ Irregular pulse ☐ Pain over heart ☐ Palpitation ☐ Poor circulation ☐ Rapid heart beat ☐ Slow heart beat ☐ Swelling of ankles	**Women only** ☐ Congested breasts ☐ Hot flashes ☐ Lumps in breast ☐ Menopause _______________ Are you pregnant? ☐ yes, ☐ no If yes, how many months? _____ How many children do you have? _____ Birth control method: _________________

Any other health conditions in your past (surgeries, pins, plates etc) or things going on in you life right now I should be aware of –

____

How do you spend most of your time ☐ standing ☐ sitting

Do you think you sleep well??__________________Enough?_________________________

What are the major stressors in your life?

____

How would you rate your level of stress? 1__ 2__ 3__ 4__ 5__ 6__ 7__ 8__ 9__ 10__

Consent

I understand that the information contained within this form is considered strictly confidential. I understand that these questions are being asked to formulate the clearest picture of my health so that I may receive the best and most appropriate massage therapy treatment. I have answered the questions on this health history form to the best of my ability. I give permission to Carol Fellowes RMT to contact any of my other health care providers to obtain more information if needed. I give consent for this information to be disclosed to my other health care providers and for the purposes of billing for health benefit claims.

I acknowledge I have discussed the following with my healthcare provider:
a. The condition that the treatment is to address;
b. The nature of the treatment;
c. The risks and benefits of that treatment; and
d. Any alternatives to that treatment.
I have had the opportunity to ask questions and receive answers regarding the treatment.
I consent to the treatments offered or recommended to me by my healthcare provider, including joint and soft tissue manipulation. I intend this consent to apply to all my present and future care with Carol Fellowes RMT.

Dated this ______day of _______________ 20____

X______________________________ ____________ X____

Patient signature (or Legal Guardian) Signature of Witness

Print Name:____________________________________ Print Name:_____________________ ____________

Policies

- Payments for Massage Therapy with Carol Fellowes RMT are due at the time of treatment. If you have coverage through an employment plan or other third party, you are directly responsible for payment. Receipts are issued upon payment and can be used for reimbursement.
- Direct billing through Blue Cross is available.
- Requests for release of information or reports are required in writing and are subject to fees.
- Your appointment time is reserved especially for you. If you are unable to make your appointment, **24 hours** notice is required for you to reschedule. If you miss your appointment time without 24 hours notice you will be charged the full amount owing for your appointment (Blue Cross and other health insurance companies do not cover this fee ☺)
- In an effort to respect everyone's time (yours, mine, the client scheduled after you, I ask that you are **on time** (or even a bit early) for your scheduled time so as to get the full time allotted to you for assessment and treatment ☺.

I have read and understand the policies noted.

X____________________________________ Date:_____/_____ /______
Signature of client and/or guardian