

# Be The Change

## 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? \_\_\_\_\_

**RESPIRATORY**

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

Is there a family history of any of the above? \_\_\_\_\_

**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
- ear aches

**SKIN**

- skin conditions
- 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? \_\_\_\_\_

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

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

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Have you had surgery? Please list dates and types. \_\_\_\_\_

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

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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 musculoskeletal 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 comfortability.

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 achiness 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  
Genevieve Poirier, RMT  
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[bethechange@bethechangept.com](mailto:bethechange@bethechangept.com)

## 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 60\$.**

Please sign below to consent to these terms

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