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 not 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 √, 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
__ ear aches

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.

__ contact lenses/glasses
__ artificial joints/body parts
__ hearing aids
__ special equipment
__ internal pins/plates/wires/screws
__ regular exercise
__ sleep well
__ drink plenty of water
__ good eating habits

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:_____