DoB _____

Gender _____

LIFT MASSAGE THERAPY

Elevate Your Health

PATIENT INTAKE FORM

Patient Name: _____ Date: _____

Reason for Treatment: _____

Please describe the area of discomfort: _____

Describe the onset: ☐Sudden ☐Gradual ☐Unusual Activity

Date of Injury: _____

Type of Pain: ☐Sharp ☐Burning ☐Dull ☐Aching ☐Shooting
☐Other _____

What aggravates the pain? _____

What relieves the pain? _____

Does the pain affect your daily activities? ☐Yes ☐No
If yes, how? _____

Is pain worse in the: ☐Morning ☐Evening

Do you experience other symptoms?
☐None ☐Popping ☐Giving way ☐Numbness ☐Grinding
☐Weakness ☐Vomiting ☐Other _____

Has this condition occurred before? ☐Yes ☐No
If yes, was it resolved? ☐Yes ☐No

Are you taking any medications? ☐Yes ☐No
If yes, what type of medications? ☐Sleep ☐Pain Killer ☐Laxative
☐Muscle Relaxants ☐Anti-depression
☐Anti-inflammatory ☐Other: _____

Are you currently seeing another medical practitioner(s)?
☐MD ☐RMT ☐Physio ☐Chiropractor ☐Acupuncturist
Other: _____

Have you had any other motor vehicle accidents, surgery or illness? ☐Yes ☐No

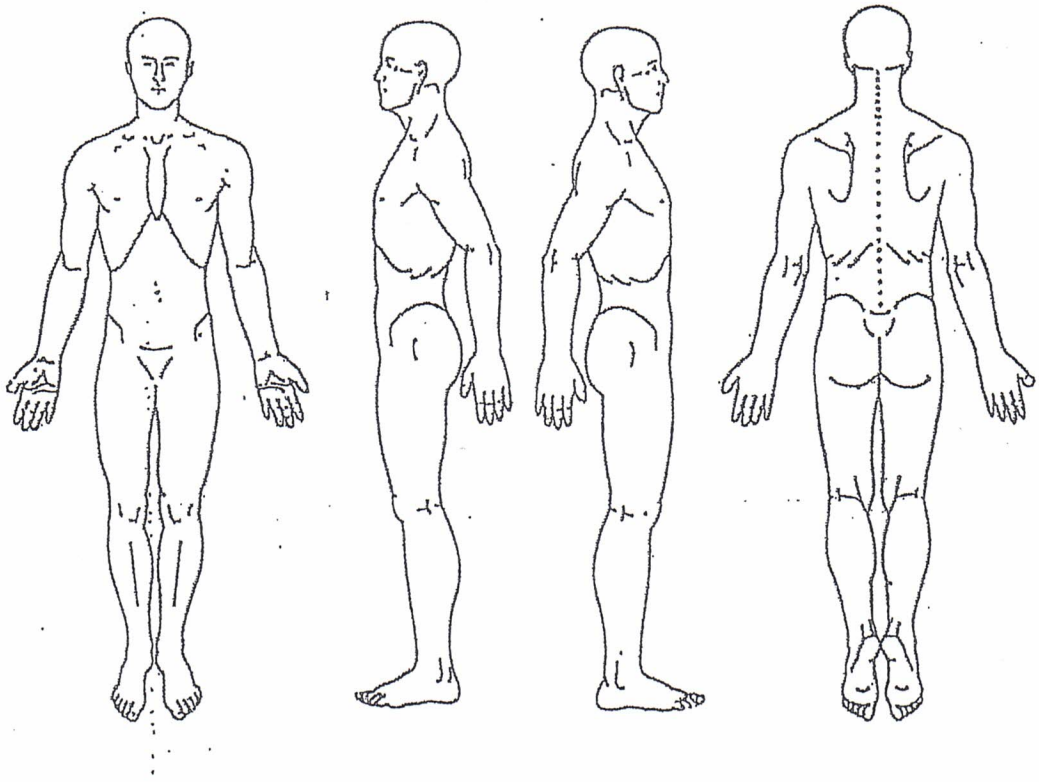
If yes, please describe: _____

What is your occupation? _____

Does your job involve extended periods of: ☐Sitting ☐Standing ☐Heavy Lifting

☐Computer ☐Other: _____

Please indicate with an "x" where you are experiencing pain:



Please indicate with an "x" the level of pain you are experiencing:

0 _____ **10**

Least Worst

MEDICAL HISTORY

Have you ever had or do you currently have:

	Past	Current	No
Heart Condition	☐	☐	☐
Stroke	☐	☐	☐
Recent Surgery	☐	☐	☐
Dislocations	☐	☐	☐
Cancer	☐	☐	☐
Fractures	☐	☐	☐
Head Injury	☐	☐	☐
Headaches	☐	☐	☐
Seizures	☐	☐	☐
Jaw Pain	☐	☐	☐
Diabetes	☐	☐	☐
Respiratory Condition	☐	☐	☐
Medical implants	☐	☐	☐
High/low blood pressure	☐	☐	☐

	Past	Current	No
Skin Condition	☐	☐	☐
Circulatory Condition	☐	☐	☐
Kidney Condition	☐	☐	☐
Contagious infection	☐	☐	☐
Digestive problems	☐	☐	☐
Arthritis	☐	☐	☐
Insomnia	☐	☐	☐
Fainting	☐	☐	☐
Spinal injury	☐	☐	☐
Sprains/Strains	☐	☐	☐
Pregnancy	☐	☐	☐
Allergies	☐	☐	☐
Steel pins	☐	☐	☐

Name _____

Date _____

PATIENT CONSENT

Victor Pelz RMT makes every effort to ensure that your treatment is safe and effective.

Massage therapy involves manipulation of soft tissues and joints of the body, and the approach to treatment may vary depending on the patient's condition(s).

- **Please read this document carefully and completely.**
- **<u>DO NOT SIGN THIS DOCUMENT</u> before speaking with your RMT.**

Before any assessment or treatment begins the following items will be discussed:

- my goals for my treatment;
- the nature and purpose of the proposed assessment and treatment and how they will address my goals;
- the possible alternative methods of treatment for example: general relaxation gentle massage, deep tissue specific techniques, hydrotherapy etc;
- the risks involved, including the possible complications and side effects, examples of which include: aching, discomfort, short term aggravation of symptoms, skin irritation, bruising, nausea, dizziness and/or new areas of pain or other symptoms that may arise
- the areas of my body that will be touched during treatment and why;
- my options for disrobing prior to the treatment; and
- my options for draping during the treatment.

By initialing the following statements I acknowledge that:

__ BEFORE SIGNING THIS FORM, my RMT discussed the above elements of the General Treatment Plan with me

__ I confirm I agree with the proposed General Treatment Plan.

__ I confirm I have no concerns with the treatment plan; OR I confirm that I have discussed my concerns about the Treatment Plan with my Therapist BEFORE signing this document. Those concerns were:

_____

_____

__ I confirm my RMT has addressed my concerns to my satisfaction before the treatment has begun.

__ I agree to alert my RMT immediately if I develop a concern at any time

__ I authorize and consent to the RMT performing the treatments described to me in the Treatment Plan.

__ I acknowledge that I may withdraw my consent to this treatment at any time.

__ I agree to tell my RMT if my goals of treatment change, as they may need to amend the Treatment Plan.

__ I agree to tell my RMT immediately if I withdraw my consent.

My initials indicate that I acknowledge and understand that:

__ It is important for the RMT to know my relevant medical history.

__ I have disclosed to the RMT all medical conditions, including any mental or emotional conditions for which I have received treatment within the last 12 months.

__ I will disclose any new condition(s) that may develop after my completion of this form.

__ The information disclosed by me is true and complete to the best of my knowledge.

__ I acknowledge and confirm that no guarantee or assurance of results has been made to me regarding my treatments.

__A copy of this consent form will be emailed or printed and given to me for my records.

At any time before or during the massage therapy treatment, you have the right to ask that the treatment or the portion of the treatment be discontinued, or you may inquire about the purpose of any technique being used. If at any time you have questions or concerns related to the treatment, you are encouraged to communicate them so that there may be clarification or modification of the treatment.

This case history and consent form will be kept as part of your patient file. All information within your file will be kept confidential. In order to provide high quality care, Victor may contact your other medical practitioners with regard to this specific health issue.

You will be required to pay for any treatment related fees which have not been or are not covered by your insurance. These fees include, but are not limited to: treatment fees, patient visit charges, medical-legal report fees, clinical record fees, and cancellation fees.

Please take into account that your massage therapy session will include time for administration (including obtaining consent, charting and taking payment), preparation, a physical assessment, hands on treatment, and self-care instruction. **Longer treatment times allow for more hands on time.**

Please sign below to indicate that you have read and understood the above information and that the information you have provided is accurate.

Date_____

Patient Name (please print) _____

Signature (or guardian if under 18) _____