NOVO HEALTHNET LIMITED

MASSAGE THERAPIST INTAKE FORM (PLEASE PRINT)

PATIENT INFORMATION

TITLE:	FIRST: MIDDLE:	LAST:	DOB:
STREET ADDRESS:		CITY:	POSTAL CODE:
P.O. BOX:	PRIMARY TEL:	SECONDARY TEL:	
EMAIL ADDRESS:		**Your email address will only be used by our clinic to communicate with you. It will not be sold or distributed.**	
EMERGENCY CONTACT NAME & NUMBER:	OCCUPATION:	HEIGHT:	
DOCTOR:	ADDRESS:	TEL:	FAX:
REFERRAL DETAILS:	(PLEASE TELL US HOW YOU HEARD OF BACK ON TRACK)		

Have you ever experienced a Professional Massage Therapy Treatment before? YES ☐ NO ☐ **When?**

HEALTH HISTORY: Please indicate conditions you are experiencing, or have experienced:

Head/Neck
- ☐ Vision (loss) problems
- ☐ Ear (Hearing) problems
- ☐ Jaw (TMJ) problems
- ☐ Headache/Migraine

Respiratory
- ☐ Chronic cough
- ☐ Shortness of breath
- ☐ Bronchitis
- ☐ Asthma
- ☐ Emphysema
- ☐ Sinus problems
- ☐ Smoking

Skin
- ☐ Skin Condition:
- Type: _____
- ☐ Rashes/Bruise easily

Infections
- ☐ Hepatitis
- ☐ TB
- ☐ HIV, AIDS
- ☐ Herpes
- ☐ Plantar Warts
- Other: _____

Cardiovascular
- ☐ High/Low Blood Pressure
- ☐ Chronic Congestive Heart Failure
- ☐ Heart Attack
- ☐ Phlebitis
- ☐ Stroke/CVA
- ☐ Pacemaker or other
- ☐ Heart Diseases
- ☐ Bleeding Disorders
- ☐ Varicose Veins
- ☐ Cancer
- ☐ Liver
- ☐ Gallbladder
- ☐ Kidney
- ☐ Insomnia
- ☐ Arthritis:

Women
- ☐ Pregnancy
- Due Date: _____
- ☐ Menstrual Problems
- ☐ C-section
- ☐ Gynecological Surgery
- Type: _____
- ☐ Menopause

Soft Tissue/ Joint Discomfort & Nature
- ☐ Neck:_____
- ☐ Upper Back: _____
- ☐ Low Back: _____
- ☐ Mid Back: _____
- ☐ Shoulders:_____
- ☐ Arms:_____
- ☐ Hands/wrists: _____
- ☐ Legs/knees: _____
- ☐ Ankles:_____
- ☐ Fractures
- Location: _____
- Date: _____
- ☐ Dislocations
- Location: _____
- Date: _____

Other Conditions
- ☐ Loss of Sensation
- ☐ Diabetes (onset)
- ☐ Allergies
- Type: _____
- ☐ Osteoporosis
- ☐ Epilepsy
- ☐ Cancer
- ☐ Liver
- ☐ Gallbladder
- ☐ Kidney
- ☐ Insomnia
- ☐ Arthritis
- Areas: _____
- ☐ Stress
- ☐ Scoliosis
- ☐ Hyper/Hypo

MEDICATIONS: _____
_____
_____
_____
_____

Surgeries? If so, the nature and when: _____

Motor Vehicle Accident? If so, the nature and when: _____

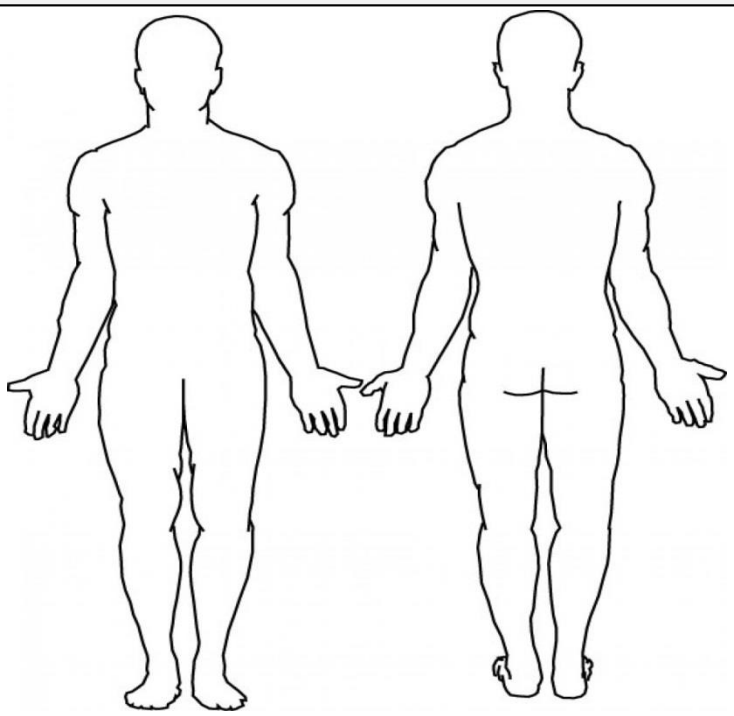
Of Special Note: (Presence of internal pins, wires, artificial joints, special equipment such as wheel chair, crutches, walker, etc)

_____

Back on Track Physiotherapy

Massage Therapy

CONSENT TO TREATMENT



***PLEASE CIRCLE YOUR AFFECTED AREAS IN THE DRAWING ABOVE**

Dear Client:

Depending on our assessment, we may be treating you while you are on your stomach, back, and/or side. We will work several musculoskeletal structures of which we will describe before each and every treatment session.

You will be covered by a sheet at all times, except for the areas that we will be working on. If needed, we may use pillows under your abdomen and/or legs in order to make you more comfortable and support your lower back.

Some risks of treatment are that some techniques may be deeper or more uncomfortable than others. We will adjust our pressure to your comfort level and will be checking with you during the treatment. It is possible you may feel side effects such as achiness the very next day, however if you follow the home-care suggestions we give you after each treatment, this is less likely to happen. It is also possible that without treatment, your condition may get worse, stay the same, or get better.

With treatment, your symptoms and healing process time may decrease. To compliment Swedish Massage Therapy, we may use hydrotherapy as well as a variety of assessment and treatment techniques. In addition, we may refer you to another type of therapist, depending on your progress with your massage treatments.

We will suggest a frequency of treatment specifically tailored to your needs, as well as a re-assessment time to evaluate your progress. It is your right to **stop or modify your treatment at any time.**

For any Missed Massage Treatment, you will be charged in accordance with the RMTAO as follows: 2nd missed massage – 50% of the massage fee / 3rd missed massage – 100 % of the massage fee. We allocated this time slot for you and your health and without proper notice, it is difficult to schedule another client who may need the treatment time.
Your consent here is provided and may be revoked at any time should you choose to do so.
Do you consent to treatment? YES NO

Thank you and enjoy your treatment.

Signature:_____ Date:_____

NOVO HEALTHNET LIMITED

MASSAGE THERAPIST INFORMED CONSENT

As a matter of ethics and law there is an obligation, prior to examination and treatment, to disclose any material risk to the patient to obtain a valid informed consent. As part of the massage treatments, certain procedures and devices may be utilized such as the use of heat, ice, electrotherapy, ultrasound, massage and manual therapy. As part of the rehabilitation program (kinesiologist, occupational therapist or physical therapist assistant) certain testing procedures, devices and equipment may be utilized such as weight machines, exercise, cardiovascular work and functional tasks. I have had the opportunity to discuss with the massage therapist and/or other clinical staff, the nature and purpose of treatments. I understand the results are not guaranteed. I further understand, and I am informed that there are some very slight risks to treatments, including, but not limited to, muscle strains, sprains, disc injuries, and burns have been made aware that there are remote chances of injury and that appropriate tests will be performed to help identify if I may be susceptible to risk or injury

Patient Signature: _____ Date: _____

Parent/Guardian Signature: _____ Date: _____

Witness Signature: _____ Date: _____

NOVO HEALTHNET LIMITED

CONFIDENTIAL CONSENT, AUTHORIZATION & DIRECTION TO DISCLOSE PERSONAL INFORMATION

I, _____
(Print Full Name)

Of_____
(Print Full Address)

Hereby consent to the sharing and / or exchange of written and/or verbal information between Novo Healthnet Limited and:

_____

_____

_____
(Print full names and institutions of affiliation)

In respect of

_____
(Print name of the client)

_____
(Date of birth)

Information to be released related to the above-named injury or illness and pertains to the development of treatment and nutritional plans.

I understand that this consent is subject to revocation at any time, except for such action that has already been taken.

A photocopy of this authorization shall have the same validity as the original.

Dated the _____ day of _____, 20____

_____ _____

(Witness) **(Signature)**

Cancelation Policy

DATE: _____

Name: _____ DOB: _____
DOL: _____ Claim #: _____

We understand that unplanned issues may come up and you will need to cancel an appointment. If this happens, we respectfully ask that you notify us at least 24 hours prior to your appointment time.

Our therapists want to be available to meet your needs as well as the needs for all of our patients. When a patient does not show up for a scheduled appointment, another patient loses the opportunity to be seen.

If we are not provided with the appropriate notice, you will be responsible for a Missed Treatment charge of $50.00. For any Missed Massage Treatment, you will be charged in accordance with the RMTAO as follows: 2nd missed massage – 50% of the massage fee / 3rd missed massage – 100 % of the massage fee.

This charge will not be billed to any third-party payors, you will be billed, and it must be paid by you for you to continue to be treated under your claim. Under certain circumstances management may waive this fee.

By signing below, you understand and agree to the cancelation and payment policy.

_____ _____
Patient's Name Witness Name

_____ _____
Patient's Signature Witness Signature