Patient Intake Form

Patient information contained within this form is considered strictly confidential.

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

_____ **Sharing of My Patient Record:** My initials confirm that I request and authorize my RMT to provide to the Clinic and to other health care practitioners who provide me with treatment, copies of any patient record created by my RMT. I understand this will enable the Clinic to maintain a complete patient record on my behalf. I understand that I may revoke this permission in writing at any time in the future.

Name: _____ **Date:** _____

Insurance: _____ (dd/mm/yr)

Date of Birth: _____ ☐ **male** ☐ **female**

Address: _____

_____

_____

Marital status

S	M	W	D	SEP

Phone #: home: _____ **work:** _____

E-mail address: _____

Occupation: _____ **Employer:** _____

Mark (c) for current problems, check ☑ and indicate the age when you had any of the following:

General
- ☐ Allergies
- ☐ Depression
- ☐ Dizziness
- ☐ Fainting
- ☐ Fatigue
- ☐ Fever
- ☐ Headaches
- ☐ Loss of sleep
- ☐ Mental illness
- ☐ Nervousness
- ☐ Tremors
- ☐ Weight loss / gain

Muscle / Joint
- ☐ Arthritis / rheumatism
- ☐ Bursitis
- ☐ Foot trouble
- ☐ Muscle weakness
- ☐ Low back pain
- ☐ Neck pain
- ☐ Mid back pain
- ☐ Joint pain

Skin
- ☐ Boils
- ☐ Bruise easily
- ☐ Dryness
- ☐ Hives or allergies
- ☐ Itching
- ☐ Rash
- ☐ Varicose veins

Eye, Ear, Nose & Throat
- ☐ Colds
- ☐ Deafness
- ☐ Ear ache
- ☐ Eye pain
- ☐ Gum trouble
- ☐ Hoarseness
- ☐ Nasal obstruction
- ☐ Nose bleeds
- ☐ Ringing of the ears
- ☐ Sinus infection
- ☐ Sore throat
- ☐ Tonsilitis
- ☐ Vision problems

Gastrointestinal
- ☐ Abdominal pain
- ☐ Bloody or tarry stool
- ☐ Colitis / Crohn's
- ☐ Colon trouble
- ☐ Constipation
- ☐ Diarrhea
- ☐ Difficult digestion
- ☐ Diverticulosis
- ☐ Bloated abdomen
- ☐ Excessive hunger
- ☐ Gallbladder trouble
- ☐ Hernia
- ☐ Hemorrhoids
- ☐ Intestinal worms
- ☐ Jaundice
- ☐ Liver trouble
- ☐ Nausea
- ☐ Painful defication
- ☐ Pain over stomach
- ☐ Poor appetite
- ☐ Vomiting
- ☐ Vomiting of blood

Genitourinary
- ☐ Bed-wetting
- ☐ Bladder infection
- ☐ Blood in urine
- ☐ Kidney infection
- ☐ Kidney stones
- ☐ Prostate trouble
- ☐ Pus in urine
- ☐ Stress incontinence

Urination
- ☐ Overnight more than twice
- ☐ More than 8x in 24hrs
- ☐ Decreased flow/force
- ☐ Painful urination
- ☐ Urgency to urinate

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

Respiratory
- ☐ Chest pain
- ☐ Chronic cough
- ☐ Difficulty breathing
- ☐ Hay fever
- ☐ Shortness of breath
- ☐ Spitting up phlegm / blood
- ☐ Wheezing

Women only
- ☐ Congested breasts
- ☐ Hot flashes
- ☐ Lumps in breast
- ☐ Menopause
- ☐ Vaginal discharge

Menstrual flow
☐ Reg. ☐ Irreg. ☐ Pain / cramps
Days of flow: ____ Lenght of cycle: _____
Date - 1st day last period: _____
Are you pregnant? ☐ yes, ☐ no
If yes, how many months? _____
How many children do you have? _____
Birth control method: _____
Date of last PAP test: _____
☐ normal, ☐ abnormal
Date of last mamogram: _____
☐ normal, ☐ abnormal

Check any of the conditions you have or have had:
- ☐ Alcoholism
- ☐ Anemia
- ☐ Appendicitis
- ☐ Arteriosclerosis
- ☐ Asthma
- ☐ Bronchitis
- ☐ Cancer
- ☐ Chicken pox
- ☐ Cold sores
- ☐ Diabetes
- ☐ Eczema
- ☐ Edema
- ☐ Emphysema
- ☐ Epilepsy
- ☐ Goiter
- ☐ Gout
- ☐ Heart burn
- ☐ Heart disease
- ☐ Hepatitis
- ☐ Herpes
- ☐ High cholesterol
- ☐ HIV/AIDS
- ☐ Influenza
- ☐ Malaria
- ☐ Measles
- ☐ Miscarriage
- ☐ Multiple sclerosis
- ☐ Mumps
- ☐ Numbness/tingling
- ☐ Pace maker
- ☐ Osteoporosis
- ☐ Pneumonia
- ☐ Polio
- ☐ Rheumatic fever
- ☐ Stroke
- ☐ Thyroid disease
- ☐ Tuberculosis
- ☐ Ulcers

Please list any medication you are currently taking and why:

_____

_____

_____

_____

Patient Intake Form (side 2)

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

_____

_____

_____

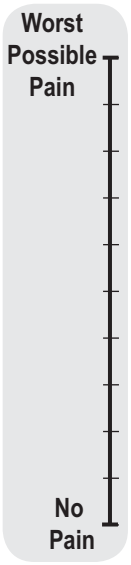
How long have you had this condition? _____ Is it getting worse? □ yes, □ no _____

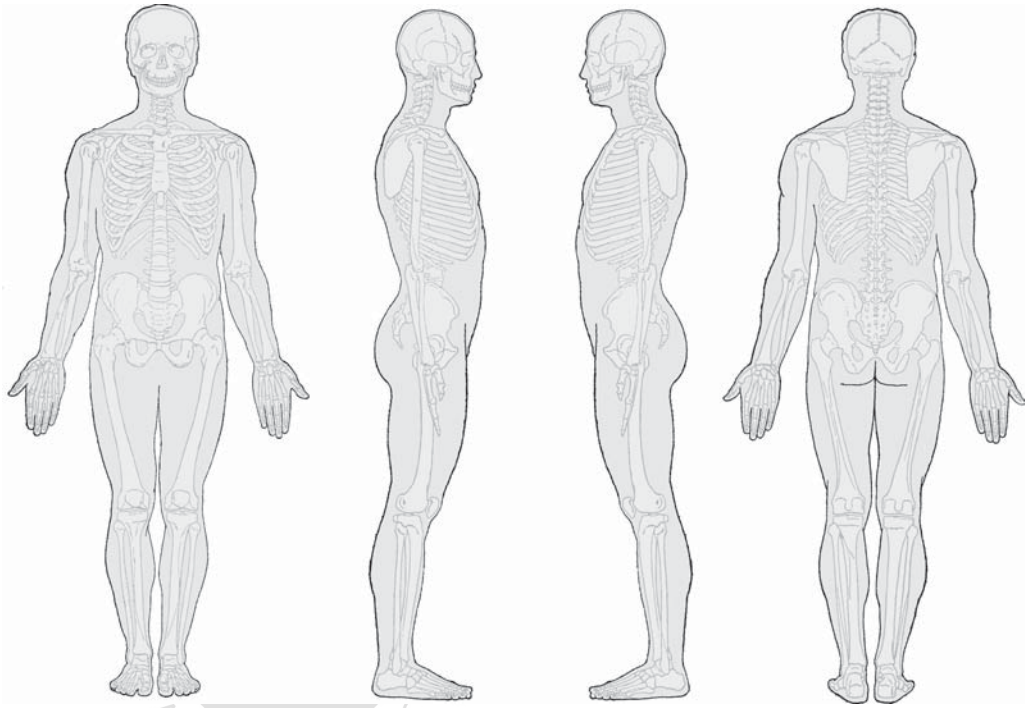
Does it bother you (check appropriate box): □ work, □ sleep, □ other: _____

What seemed to be the initial cause: _____

Please mark your area(s) of pain on the figure below

Please place a mark at the level of your pain on the scale below:





Past health history

Have you...	Yes	No	If yes, explain breifly
... been hospitalized in the last 5 year?	○	○	_____
... had any mental disorders?	○	○	_____
... had any broken bones?	○	○	_____
... had any strains or sprains?	○	○	_____
... ever used orthotics?	○	○	_____
Do you take minerals, herbs or vitamins?	○	○	_____

How is most of your day spent? □ standing, □ sitting, □ other: _____

How old is your matress? _____

When was your last physical exam? _____

Habits	none	light	mod.	heavy
Alcohol	▣	□	□	□
Coffee	▣	□	□	□
Tobacco	▣	□	□	□
Drugs	▣	□	□	□
Exercise	▣	□	□	□
Sleep	▣	□	□	□
Soft drinks	▣	□	□	□
Salty foods	▣	□	□	□
Water	▣	□	□	□
Sugar	▣	□	□	□

Family history

If any blood relative has had any of the following conditions, please check and indicate which relative(s)

□ Alcoholism	□ Cancer	□ High blood pressure
□ Anemia	□ Diabetes	□ High cholesterol
□ Arteriosclerosis	□ Emphysema	□ Multiple sclerosis
□ Arthritis	□ Epilepsy	□ Osteoporosis
□ Asthma	□ Glaucoma	□ Stroke
□ Bleed easily	□ Heart disease	□ Thyroid disease

Do you have any other health issues or concerns that our staff should be made aware of? _____

_____

CONSENT TO TREATMENT

PATIENT NAME: **DOB (DD/MM/YYYY):** / /

Please read this document, including **Schedule A**. Ask your RMT any questions you have regarding the contents of this form before you sign. You are encouraged to ask questions about your treatment at any time.

TO BE COMPLETED BY PATIENT

Disclosure of Medical History

- 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.
- The information disclosed by me is true and complete to the best of my knowledge.
- If my condition should change, I will notify my RMT before subsequent treatments.

_____ My initials indicate that I understand.

TO BE COMPLETED BY PATIENT WITH RMT PRIOR TO TREATMENT

Treatment Plan

- My goals for my treatment;
- the therapeutic rationale for the proposed treatment;
- possible alternative methods of treatment;
- the anticipated benefits and possible negative effects of the treatment, examples of which include bruising, aching, discomfort, short term aggravation of symptoms, skin irritation and/or

_____

_____

- the areas of my body where treatment will be delivered
- my options for disrobing; and
- my options for draping during the treatment.

_____ **Before signing this form**, my RMT discussed the above elements of the Treatment Plan with me.

Concerns Addressed

_____ 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:

_____

_____

Consent to Treatment:

- I consent to the RMT performing the treatments described to me in the Treatment Plan.
- I understand 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 my RMT may need to amend the Treatment Plan.
- If I have concerns during treatment, I will advise my RMT **immediately**.

_____ My initials indicate that I understand.

Confidentiality

The contents of this form and my patient records will be kept confidential unless I have expressly or impliedly consented to the release of my information or where there is a legal requirement to provide my information to a third party.

No Guarantee of Results

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

Signature of Patient*: _____ Date (dd/mm/yyyy) __ / __ / _____

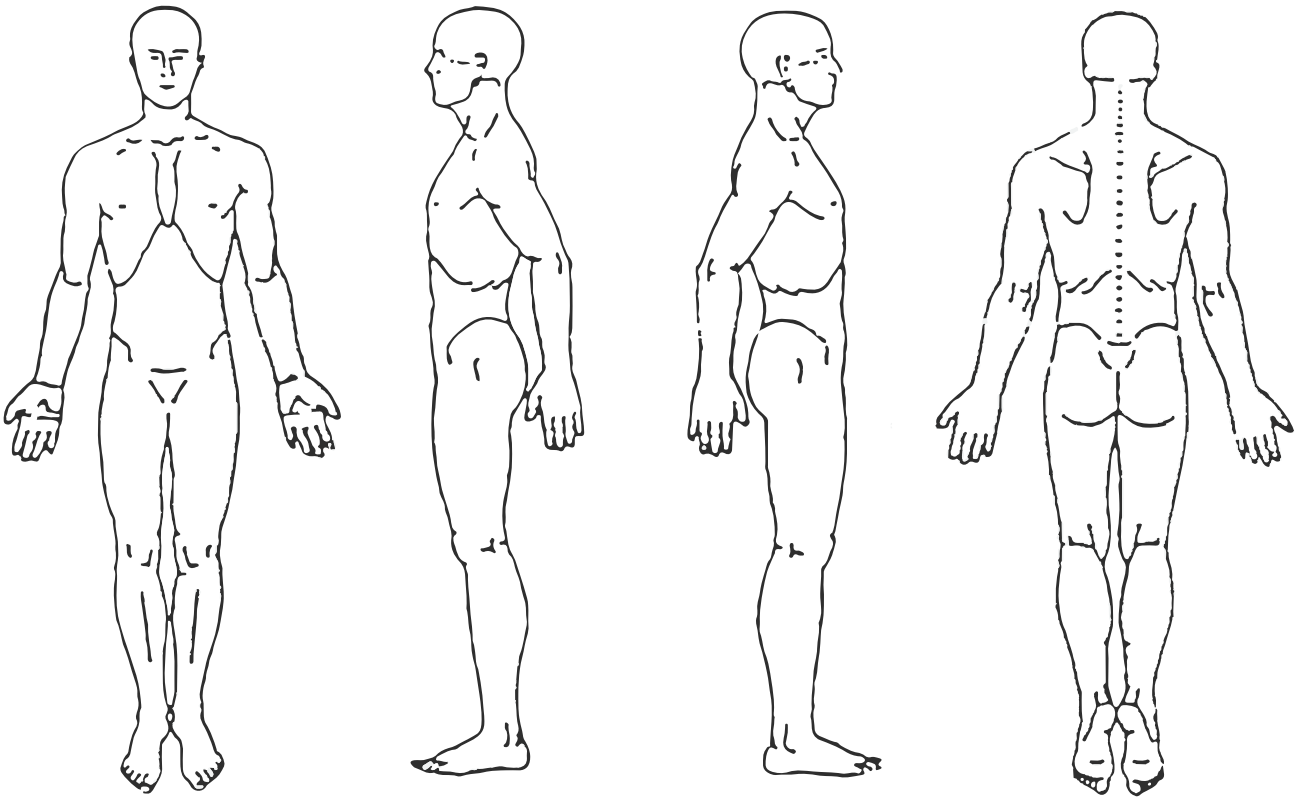
(* In the case of a person incapable of providing consent, signature of Parent or Guardian, in which case
the Name & Relationship of Person Signing: _____.)

SCHEDULE A
Consent to Treatment of:

PATIENT NAME: **DATED (DD/MM/YYYY):** / /

Body Areas to be Treated

I acknowledge and confirm that this document forms part of the **Consent To Treatment** document previously signed by me and also applies to this treatment on this date.
I consent that the areas of my body circled on the diagram below may be touched by the RMT during my treatments:



It may be necessary for the RMT to adjust their treatment plan during my treatment, in which case they will discuss that with me.

Signature of Patient*: _____ Date (dd/mm/yyyy) __ / __ / _____

(* In the case of a person incapable of providing consent, signature of Parent or Guardian, in which case the Name & Relationship of Person Signing: _____.)