PENINSULA

RMT INTAKE FORM

Today's Date:_____ Name:_____

Date of Birth:_____ Gender: M/F BC Care card#_____

Phone #: (home)_____ (cell)_____(e-mail) _____

Address: _____

Emergency Contact: Name (Relation):_____
Phone number:_____

How did you hear of the clinic?_____

Other Health Care Providers

Name:_____ Type of Practitioner_____ Phone #_____
Name:_____ Type of Practitioner_____ Phone #_____
Name:_____ Type of Practitioner_____ Phone #_____

How would you describe your general state of health? *Excellent *Good *Fair *Poor

What are your current health concerns, in order of importance?

1. _____ How Long?_____ Prior treatment_____
2. _____ How Long?_____ Prior treatment_____
3. _____ How Long?_____ Prior treatment_____
4. _____ How Long?_____ Prior treatment_____

Current medications and supplements (attach list if extensive):_____
_____
_____

Medical History

Major illnesses (describe):_____
> Allergies_____ > Birth defects_____
> Asthma_____ > Heart Disease_____
> Arthritis_____ > Hypertension_____
> Cancer_____ > Diabetes_____

Any previous hospitalizations or surgeries (describe)? _____
_____

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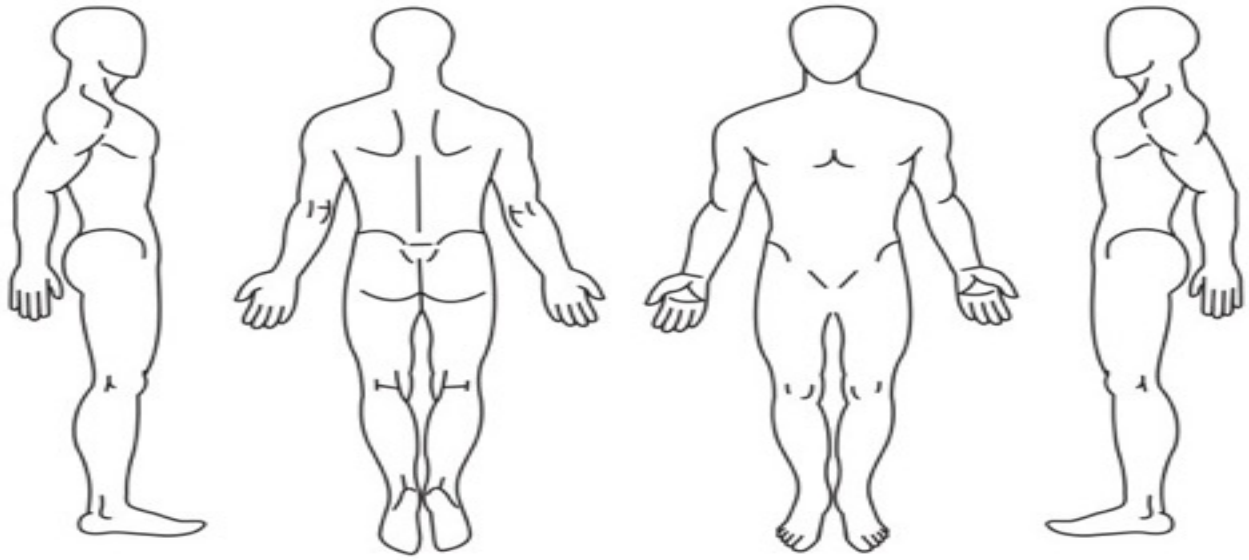
PENINSULA



Please circle any specific areas you would like the massage therapist to concentrate on during this session

Extended Insurance coverage:
Cardholder Name/DOB: _____
Name of Insurance company:_____
Group policy/ID: _____

Consent to treatment - Please read and sign.

I, _____ give consent for treatment through Peninsula Naturopathic Clinic. I understand that in most cases it may take time to see improvements to my health and that follow up visits are essential to achieving long term health goals. Through commitment and personal responsibility to my health, massage therapy will work to my benefit.

Effective massage therapy treatment may involve diagnostic testing, homecare exercises and modifications to daily activities. Referrals to other health care practitioners, such as acupuncture, chiropractic and physiotherapy may be recommended, and my RMT will explain and discuss the relevancy of any recommendation in relation to my personal health goals.

Direct verbal consent will be obtained prior to each treatment, once I have been given clear instruction of what the treatment will involve.

All of the above is true to my knowledge and have read and acknowledge the disclaimer

SIGNED_____ DATE_____