Visionary Health Medical Educational Clinic (VHMEC)
5359 Dundas St West Unit 108, Toronto, ON M9B1B1 647-478-9029 FAX: 647-557-3323
vhmec108@gmail.com info@vhmec.com www.vhmec.com

RMT Intake Form

In order to ensure safe and optimum care, your Massage Therapist/Aesthetician requires the following information. Please note that this information will be kept confidential unless allowed or required by law. Your written permissionwill be required to release any information.

CONTACT INFORMATION

First Name: _____ Last Name: _____ Date of Birth: DD/MMM/YYYY

Address: _____

City, Prov.: _____ Postal Code: _____

Occupation: _____ Phones (H): _____ (Cell): _____

Email: _____

Emergency Contact Name: _____ Phone Num.: _____

Physician Name: _____ Physician Number: _____

Have you received massage therapy before? YES / NO

Have you been referred to massage therapy by your healthcare provider? YES / NO

How did you find out about our clinic? _____

PAST MEDICAL HISTORY

Please indicate the conditions you are experiencing (C – Current) or have experienced (P – Past):

Cardiovascular

- ☐ Stroke/CVA
- ☐ Heart attack
- ☐ High blood pressure
- ☐ Low blood pressure
- ☐ Angina/Chest pain
- ☐ Congestive heart failure
- ☐ Irregular heart rate
- ☐ Phlebitis/Varicose veins
- ☐ Pacemaker

Skin

- ☐ Eczema
- ☐ Psoriasis
- ☐ Acne
- ☐ Other _____

Infectious Diseases

- ☐ Hepatitis Type
- ☐ HIV
- ☐ Tuberculosis
- ☐ Herpes
- ☐ Other _____

Allergies / Sensitivities

- ☐ Food _____
- ☐ Oils _____
- ☐ Lotions _____
- ☐ Creams _____
- ☐ Drugs _____
- ☐ Latex _____
- ☐ Cold
- ☐ Others: _____

Respiratory

- ☐ Chronic cough
- ☐ Shortness of breath
- ☐ Bronchitis
- ☐ Asthma
- ☐ Emphysema
- ☐ Other _____

Head / Neck

- ☐ Headaches, Type: _____
- ☐ Neck pain / Stiffness
- ☐ Ear problems
- ☐ Hearing loss
- ☐ Vision problems
- ☐ Vision loss
- ☐ Speech problems

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Other conditions

- ☐ Arthritis, type?_____
- ☐ Circulatory problems
- ☐ Epilepsy
- ☐ Osteoporosis/Osteopenia
- ☐ Slow healing / Hemophilia
- ☐ Cancer, where?_____
- ☐ Thyroid problems, type?_____
- ☐ Bowel / Bladder problems, type?
- ☐ Diabetes, onset: _____
- ☐ Altered/Loss of sensation, where?

Mental Health

- ☐ Depression
- ☐ Anxiety / Panic Attack
- ☐ Bipolar Disorder
- ☐ Attention Deficit Hyperactivity Disorder (ADHD)
- ☐ Schizophrenia

Family History

- ☐ Cancer
- ☐ Heart disease
- ☐ Diabetes
- ☐ Arthritis
- ☐ Respiratory
- ☐ Other: _____

Female conditions

- ☐ Pregnancy, Due date: _____
- ☐ Gynecological conditions

☐ Previous Surgeries

For what condition? _____

Date: _____

Type: _____

☐ Previous Injuries

Where? _____

Date: _____

Type: _____

Have you had any of the following tests done recently or previously? YES / NO

☐ X-ray ☐ CT scan ☐ MRI ☐ EMG ☐ Bone scan ☐ Blood work ☐ Urinalysis

If Yes, please state when and where? _____

GENERAL HEALTH

What is your main reason for coming in today? _____

List all **medications** you are taking (please give the name, dose and length of time on the medication):

Are you currently or have you previously received any of the following treatments (chiropractic, radiation, massage therapy, chemotherapy, physiotherapy)? YES / NO

If yes, please list when and where? _____

Have you had any unexplained weight loss in the last month? YES / NO

Do you wear orthotics or special shoe inserts? YES / NO

How often do you exercise a week? ☐ None ☐ 1x ☐ 2x ☐ 3x ☐ 4x ☐ 5x or more

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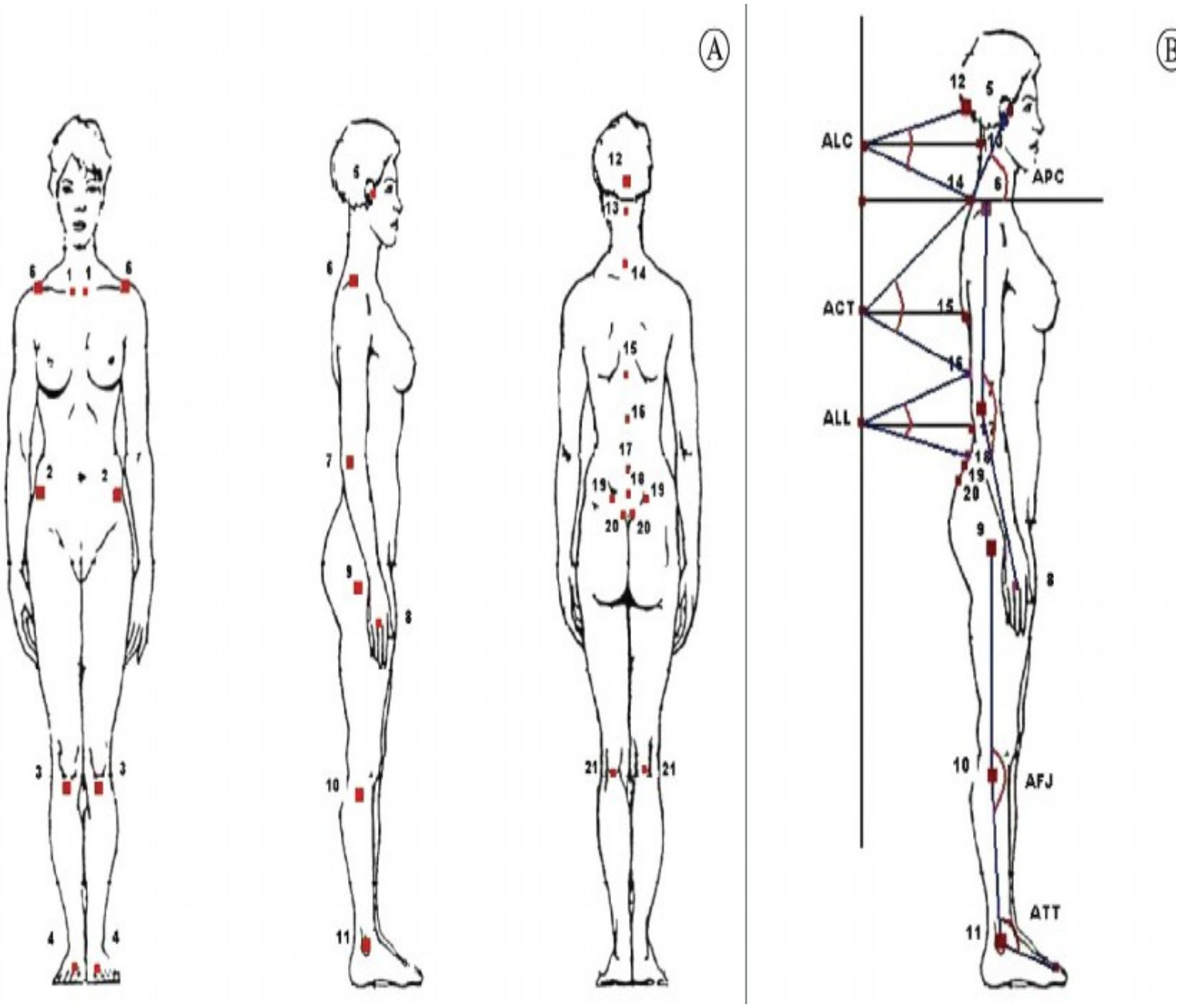
Rate your pain on a scale from 1-10 (1 is mild, 10 is worse): _____

Use the following descriptive symbols on the body outline to describe the location of your complaint.
Ache - **A** Burning - **B** Numbness - **O** Pins & Needles - **I** Sharp/Stabbing - **S** Other - **X**



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INFORMED CONSENT FOR MASSAGE THERAPY/AESTHETICS

TO THE PATIENT: You have the right, as a patient, to be informed about your condition and the recommended treatments and procedures to be used so that you make an informed decision whether or not to undergo the recommended procedure(s) after knowing the benefits and risks involved. This document is not meant to alarm you; it is simply to inform you that you may give or withhold your consent to treatment.

If you refuse any special procedure this will not affect you receiving other care or future treatments.

- I voluntarily request Yun Lin (RMT) and/or Olha Sanovska (Aesthetician, Manual Osteopath) to examine and treat my health conditions. I understand that the course of care therapy may include the use of multiple modalities including traditional Swedish Massage techniques, Positional Release; LAS, Joint Mobilization, Oscillation, Hot Stone massage, Lymphatic Drainage.
  I understand that there are some health risks with treatment from these therapies.
- These include, but are not limited to
  - Some minor pain, bruising and discomfort the day after treatment.
  - Aggravation of pre-existing symptoms and conditions from re-activation of the body's corrective healing capacities by energetic medicines
- I understand that my verbal consent to a specific treatment and my willing participation in receiving these therapies after explanation of benefits and risks is sufficient to indicate my consent to receive treatment. I waive the option of signing a consent form to treat for each and every special procedure at each treatment date.
- I understand that there is some minimal risk if I have any of the following: chronic fatigue, depression, insomnia, diabetes, damaged/sore skin, fragility of capillaries, oncological diseases, influenza, varicose veins, systematic diseases
- I understand that I am free to pursue other medical opinions and treatments including conventional medical care at any time.
- I understand that I have the right and the opportunity to ask questions about my condition, discuss options at anytime.
- I understand there may be complications and risks related to the recommended procedure(s) and that I may request additional information regarding complications and risks (side effects) and refuse any specific treatment at any time.
- I understand that payment is due in full at the time of service.
- I understand that no warranty or guarantee regarding a promise of cure as a result of care is provided for anycondition.
- I understand that a record will be kept of the health services provided to me and will be kept confidential.
- I agree to allow my medical records be shared with other medical professionals within Visionary Health only. Any other request of medical records must require a *medical release form* before releasing medical records to anyoneother than the patient, unless so directed by myself or required by law.
- Payment of services, dispensary items, and other fees are due in full at each visit.
- A Missed Appointment Fee of $50 will be charged for any missed appointments or cancellations later than 9:30am of the business day prior to your appointment. (A business day is defined as Monday to Friday, excluding holidays)
- I certify that I have read this form or have had it read to me, and that I understand its content and meaning. I have sufficient information to give this informed consent.

Patient Name (please print) Patient Signature:

_____ _____

Date:

_____

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CONSENT TO TREATMENT OF SENSITIVE AREAS

TO THE PATIENT: After initial assessment, your RMT or Aesthetician may identify issues that could originate in the sensitive areas (chest wall, buttocks, upper inner thighs or breasts). The RMT or Aesthetician may need to further assess and devise a treatment plan that include one or more of these areas. As the patient, you have the right to be informed about your condition, recommended treatments and procedures to be used so that you make an informed decision whether or not to undergo the recommended procedure(s) after knowing the benefits and risks involved. This document is not meant to alarm you; it is simply to inform you that you may give or withdraw your consent to treatment at any given point.

I,_____(name), have requested assessment and/or treatment by Registered Massage Therapist (RMT), Yun Lin and/or Aesthetician & Manual Osteopath, Olha Sanovska, for treatment of the clinically relevant areas indicated below (please initial the one applicable only):

_____ Buttocks (gluteal muscles)
_____ Chest Wall Muscles
_____ Upper Inner Thigh(s)
_____ Breast (s)

The RMT or Aesthetician has explained the following to me and I fully understand the proposed assessment and/or treatment:

- The nature of the assessment, including the clinical reason(s) for assessment of the above area(s) andthe draping methods to be used
- The expected benefits of the assessment
- The potential risks of the assessment
- The potential side effects of the assessment
- That consent is voluntary
- That I can withdraw or alter my consent at any time.

I voluntarily give my informed consent for the assessment and/or treatment as discussed and outlined above.Client

Name (print): _____

Client Signature:_____Date: _____

Ongoing Treatment:

I am aware that the treatment of the above indicated area(s) is part of a treatment plan which has been discussed with me by my RMT. I confirm that, on the following date(s), the RMT has reviewed the treatment plan and I provide my informed consent.

Client Signature:_____Date:_____
Client Signature:_____Date:_____
Client Signature:_____Date:_____
Client Signature:_____Date: _____