RMT INTAKE FORM

Today's Date: _____

Birth Date: _____

Name: _____

Address: _____postal code_____

home phone: _____

work phone: _____

cell phone: _____

email: _____

WHAT IS YOUR PRIMARY REASON FOR SEEKING MANUALTHERAPY?

_____

IS THIS PART OF AN ICBC or WCB CLAIM? ❑ Yes ❑ No
If yes, please give the Adjuster's Name, phone number & your claim # for our reference only. No information about your treatment will be shared without your authorization.

_____

Are you currently taking any medications? ❑ Yes ❑ No
If yes, please list with the reason for their use:

_____
_____
_____

CURRENT STATE OF WELL BEING
Please check which best describes you below in the following categories:

- Stress level ❑ exhausting ❑ poor ❑ minimal ❑ non-existent
- Quality of sleep ❑ restful ❑ restless ❑ lots of interruptions ❑ very poor
- Energy level ❑ minimal ❑ I have to push myself through the day ❑ lots of energy
- Eating habits ❑ poor ❑ good ❑ excellent
- Exercise habits ❑ not exercising ❑ regular activity ❑ regular routine exercise

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RMT INTAKE FORM

HEALTH HISTORY

Please check any that apply and mark current (C) or past (P)

- Surgery (ANY)
- Motor vehicle accident
- Cardiovascular disease
- Asthma
- Diabetes
- Multiple Sclerosis
- Head trauma
- Cancer
- Osteoporosis
- Crohn's disease or Colitis
- History of stroke or aneurysm
- Chronic fatigue
- Spinal disc herniation
- Rheumatoid or osteoarthritis
- Nausea/vomiting
- Indigestion
- Heartburn/acid reflux
- Tinnitus
- Epilepsy/seizures
- Spinal injury
- Hip pain
- HIV/AIDS
- Hepatitis
- Skin rash or Persistent itching
- Blurred Vision
- Double Vision
- Chest Pain
- Varicose Veins
- High/low blood pressure
- Ear infections
- Sinus issues
- Painful urination
- Mild to moderate incontinence
- Severe incontinence
- Frequent urination
- Headaches
- Migraines
- Joint pain
- Neck pain
- Lower back pain
- Upper back pain
- Knee pain

When are your symptoms/pain the worst? ❑ morning ❑ evening

SIGNED _____

TODAY'S DATE _____

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PERSONAL INFORMATION AND PRIVACY ACT

THIS FORM IS SOLELY TO INFORM YOU THAT YOUR PRIVATE INFORMATION IS ONLY USED FOR THE PURPOSE OF YOUR TREATMENT AND OFFICE ADMINISTRATIVE PUROPOSES. YOUR INFORMATION WILL NEVER BE SHARED OR SOLD FOR ANY PURPOSE UNRELATED TO YOUR TREATMENTS HERE WITHOUT YOUR PERSONAL CONSENT.

"By my signature below, I authorize collection, use and disclosure of personal information, as defined in the personal information and privacy act (PIPA), required for treatment and/or any related administrative purpose. I understand that all my personal information is confidential, and must be treated in accordance with PIPA."

Signature _____ Date _____

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Cancellation & Treatment Policy

Please check to indicate you have read through each item.

☐ I understand that my appointment time may include history taking, assessment & homecare advice as part of my clinical treatment.

☐ Your appointment time is reserved for you. Cancellation or changes to appointment times require 24 hours notice to allow for the therapist to book another patient in that time slot. Failure to do so may result in the full fee for your appointment being charged.

☐ If you arrive late to your appointment, every attempt will be made to ensure that you still receive treatment however time may be limited to that remaining in your scheduled appointment.

Date _____

Signature _____

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