Via Natural Medicine
554-A Des Meurons St. Winnipeg, MB Canada R2H 0P8
Phone: 204.615.5225 | Fax 204.615.5201
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MASSAGE THERAPY INTAKE FORM
André MacNair RMT

Personal Information

We respectfully ask that you complete this form prior to arriving for your scheduled appointment time.

Patient Name: ____________________ ____________________ **Date of Birth:** ____/____/________
First Name Last Name DD MM YYYY

Insurance Provider: __________ ________________ **Contract Plan:** __________ **Group ID:** ___________

Home Address: ______________________________ **City:** ________________ _______

Province: ____________ **Postal Code:** ____________ **Phone #:** (____) _________________

Email: ____

Emergency Contact Name: ________________ **Relationship:** ________________________

Emergency Contact's Phone #: (____) _____________

Family Doctor: __________________________ **Specialists:** ______________________________

Occupation: ____

Activities: ____

Medical Information

Reason Treatment Requested: ____

____

Seeking any other treatment? If Yes what kind?: ______________________________________

____

Current Medication(s) & dosage: ____

____

Please check all that apply - Mark *P* for present conditions and *H* for past conditions:

___ High - Low Blood Pressure
___ Phlebitis
___ Pacemaker-Similar Device
___ Bronchitis
___ Asthma
___ Colitis
___ Tuberculosis
___ Diabetes-Insulin Controlled?
___ Edema
___ Allergies

___ Chronic Congestive Heart Failure
___ Myocardial Infarction
___ Cholesterol Problems
___ Emphysema
___ Irritable Bowel Syndrome
___ Fainting-Dizziness
___ Hepatitis
___ Arthritis
___ Epilepsy
___ Pregnancy

___ Stroke
___ Heart Disease
___ Chronic Cough
___ Shortness of Breath
___ Crohn's Disease
___ Headaches
___ HIV-AIDS
___ Cancer
___ Hernia
___ Osteoporosis

Medical Information continued

Whiplash or Other MVA? if yes, please describe: ______________________________

____

____

Skin Conditions? if yes, please describe: ______________________________

____

Neurological Conditions? if yes, please describe: ______________________________

____

____

If you have further information regarding your health, please take a moment to describe below:

____

____

____

Soft Tissue-Joints - Location and nature of soft tissue and or joint dysfunction(s): ______________

____

____

Pain - List the top 3 conditions that concern you the most. The first being the most painful:

Area of Concern: 1. ____________ 2. ____________ 3. ____________

Type of Pain: 1. ____________ 2. ____________ 3. ____________

Onset: 1. ____________ 2. ____________ 3. ____________

Duration: 1. ____________ 2. ____________ 3. ____________

Aggravating Factors: 1. ____________ 2. ____________ 3. ____________

1. ____________ 2. ____________ 3. ____________

1. ____________ 2. ____________ 3. ____________

What makes it better: 1. ____________ 2. ____________ 3. ____________

1. ____________ 2. ____________ 3. ____________

1. ____________ 2. ____________ 3. ____________

Frequency-Occurance: 1. ____________ 2. ____________ 3. ____________

1. ____________ 2. ____________ 3. ____________

Thank you for taking the time to complete this intake form. We look forward to working with you to optimize your health and well being.

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André MacNair RMT

1. I understand that André MacNair is a registered massage therapist and I grant permission to provide massage therapy treatment to me as discussed.
2. I understand that any advice given to me as a patient at Via Natural Medicine is not mutually exclusive from any treatment or advice I may now, or in the future, be receiving from another health care provider.
3. I understand that I am at liberty to seek, or to continue medical care from another qualified health care provider.
4. I understand that André MacNair reserves the right to determine which cases fall outside of his scope of practice, and an appropriate referral may be recommended.
5. I understand that I am accepting or rejecting this care by my own free will.
6. I understand that no employee or practitioner at Via Natural Medicine is suggesting to me to refrain from seeking the advice of another health care provider.
7. I understand that the charges of the above mentioned treatment may not be covered by or may exceed my policy benefits.
8. I understand that 24 hours notice is required for appointment cancellation, otherwise I will be responsible for the payment of a cancellation fee.
9. I understand that any therapies recommended will be explained to me in full by André MacNair and that I will give consent to treatment based on informed consent.

I, ____________________________________ have read, understood and agree to the above statements.
First Name Last Name

Signature: ____________________________ Today's Date: ____/____/________
DD MM YYYY

Informed Consent for Communication

We value our relationship with you and would like to send you information electronically relating to Via Natural Medicine. In order to do this, we are collecting your consent to receive electronic messages from us in the form of **appointment reminders**, newsletters, upcoming events and other clinic information. Please take a moment to select either "OPT IN" or "OPT OUT". Opting in will provide Via Natural Medicine consent to communicate with you electronically. Opting out will indicate that you do not wish to receive any electronic communication from us.

Opt IN: ☐ Opt OUT: ☐

Signature: ____________________________ Today's Date: ____/____/________
DD MM YYYY