Ottawa Integrative Health Centre Inc.
1129 Carling Ave., Ottawa, ON K1Y 4G6
P: (613) 798-1000 F: (613) 798-9995 www.oihc.ca

Registered Massage Therapy Intake

Patient Information

Name_____ Date_____

Address_____

City_____ Province_____ Postal Code_____

Home Phone_____ Cell Phone_____

Work Phone_____ E-Mail_____

☐ Yes, sign me up for the monthly e-newsletter

Date of Birth *day*_____ *month*_____ *year*_____Age_____

Occupation_____

Family Doctor_____

Indicate below any other health care professional(s) that you currently consult.
☐ Physiotherapist ☐ Chiropractor ☐ MD ☐ Naturopath ☐ Other _____

Referred By_____

Reason for Massage Therapy Treatment_____

Emergency Contact Information

Name_____ Relation_____

Phone_____ E-Mail_____

The Ottawa Integrative Health Centre requires an accurate and up-to-date health history to ensure appropriate and safe massage treatment. If your health status or information changes at any point please let the therapist know. This form will be updated yearly.

All of the information, disclosed in this form or kept on file, is confidential according to the privacy policy. If you have any questions feel free to ask them of the therapist at any time. If you require your information to be released to another party, a written authorization will be required.

Ottawa Integrative Health Centre Inc.
1129 Carling Ave., Ottawa, ON K1Y 4G6
P: (613) 798-1000 F: (613) 798-9995 www.oihc.ca

Registered Massage Therapy Intake

(Instructions) To the left of each question below please indicate whether you have experienced this problem in the past (check the box under '**P'**), if you are currently experiencing the problem (check the box under '**C'**) or if there is a family history of this problem (check the box under '**F'**). Include any additional information that might be helpful on the line provided below each question.

PCF

☐☐☐ Loss of vision, hearing or skin sensation

_____

☐☐☐ Cardiovascular conditions
such as high or low blood pressure, heart disease, stroke or TIA, congestive heart failure, heat attack, phlebitis, varicose veins or cerebro-vascular accident _____

☐☐☐ Respiratory conditions
such as asthma, emphysema, bronchitis, shortness of breath or chronic cough

_____

☐☐☐ Hypersensitivities or allergies

_____

☐☐☐ Life-threatening allergies

_____

☐☐☐ Head, ear or eye conditions
such as migraines, headaches, earaches, sinus infections, dizziness, blurred or limited vision

_____

☐☐☐ Skin conditions
such as rashes, cold sores or eczema,

_____

☐☐☐ Soft tissue or joint discomfort
of the neck, upper back, mid back, low back, shoulders, arms, legs, knees or other

_____

Ottawa Integrative Health Centre Inc.
1129 Carling Ave., Ottawa, ON K1Y 4G6
P: (613) 798-1000 F: (613) 798-9995 www.oihc.ca

Registered Massage Therapy Intake

PCF

☐☐☐ Pins, wires, prosthetics, pacemaker, contact lens, artificial joints, glasses, special equipment or other

_____

☐☐☐ Infectious conditions such as tuberculosis, hepatitis, HIV, herpes or other

_____

☐☐☐ Other medical conditions
such as diabetes, epilepsy, cancer, hemophilia, kidney disease, MS, Parkinson's disease, osteoporosis, osteoarthritis, rheumatoid arthritis or other_____

Please list any prescribed medications, over-the-counter drugs or herbal or natural supplements that you are currently taking, and the reason for taking them.

_____

Describe any accidents, injuries, surgeries or major illnesses in your life.

_____

If you have consulted a Registered Massage Therapist in the past list the reason(s).

_____

Is there anything that you feel is important that has not been covered here?

_____

_____

General Health Questions

Are you currently pregnant? (due date _____)
Are you currently peri- or meno-pausal?
Are you currently post menopausal?
Do you smoke? ☐ yes ☐no
Do you exercise regularly? ☐ yes ☐no
Do you have regular, balanced eating habits? ☐ yes ☐ no
Rate you energy level ☐ high ☐low ☐just right
How do you sleep? ☐ not enough ☐ not restful ☐ well
Rate your overall health ☐ poor ☐ below avg. ☐ avg. ☐ above avg. ☐ excellent

The information listed above is complete and accurate. I understand that a record will be kept of the health services provided to me, and that it will be kept confidential and will not be released to others unless so directed by myself unless the law requires it.

Client Signature_____ Date_____

Ottawa Integrative Health Centre Inc.
1129 Carling Ave., Ottawa, ON K1Y 4G6
P: (613) 798-1000 F: (613) 798-9995 www.oihc.ca

Registered Massage Therapy Intake

Patient/Client Agreement Form

Each patient/client is required to read the following before treatment.
Your signature below acknowledges the following:

1. I understand that Naturopathic and other services provided at OIHC are not covered by the provincial government, yet their expenses may be covered by private insurance plans and may be tax deductible.

2. The fees and services have been clarified in advance. Payment is due at the end of each visit as the clinic does not bill insurance companies directly. Cash, cheque, Interac, Visa, and MasterCard (no other credit card) are acceptable methods of payment

3. Forty-eight hours notice is required when cancelling or changing an appointment. Otherwise, I understand that I will be charged for 50% of the missed appointment.

4. Items purchased are non-refundable, whether or not they have been opened.

5. I understand that natural health care is a joint responsibility between me (the patient/client) and my practitioner. Improving my lifestyle can be as important as the remedies and treatments.

6. I understand that I may contact my health care provider by phone or e-mail and that all emails will be screened by reception and forwarded to the appropriate Naturopathic doctor/practitioner.

7. I realize that integrative health care/medicine is not an isolated system and that all our health care providers welcome teamwork with NDs, MDs, DCs, RMTs, and other health practitioners.

Patient Signature_____ Date_____