**Laura Hild, RMT**

**INITIAL INTAKE FORM**

**General Patient Information**

Legal/Given name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Preferred name(s): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Gender (check all that apply)

* Man
* Woman
* Trans
* Other (please specify) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date of Birth: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (dd/mm/yy) Occupation: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

City: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Province: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Postal Code: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Tel: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Work: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Cell: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Email Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_@ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Emergency Contact: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Tel: \_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relation: \_\_\_\_\_\_\_\_\_\_\_\_\_

Family Physician: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Tel: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date of Last Appointment: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of last physical: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Are you taking any medications? If so, please list: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Current fees for my services (which include HST) are as follows:

**Service Duration Price**

Massage 120 minutes $210.00

Massage 90 minutes $155.00

Massage 60 minutes $ 105.00

Massage 45 minutes $ 85.00

Massage 30 minutes $ 65.00

Hot Stone Massage 90 minutes $175.00

Hot Stone Massage 60 minutes $125.00

Bowen Therapy Full Session $ 80.00

Bowen Therapy Half Session $ 45.00

Indie Head Massage Full Session $ 80.00

Indie Head Massage Half Session $ 45.00

Paraffin wax to hands and or feet $15.00

Paraffin wax to hands and feet $30.00

Essential Oils ( up to three kinds ) $5.00

Hot Towels ( up to four) $5.00

Kinesiotaping $5.00

Payment for services are the responsibility of the patient and are to be paid at each visit. Payments can be made by cash, cheque, or etransfer (please send to [laurahildrmt@gmail.com](mailto:laurahildrmt@gmail.com)) Cash or cheque accepted after service is rendered, etransfers must be sent prior to appointment, no more than 24 hrs in advance. A receipt will be issued following treatment which you can submit to your insurance company.

*I understand the fees and payment schedule policy \_\_\_\_\_\_\_\_\_****initials***

**Cancellation & No Show Policy**

Out of respect for your therapist and other patients, we require **24 hours minimum advance notice of cancellation**. If you cancel your appointment with less that 24 hours notice, you will be charged fifty percent (50%) of actual cost of posted fees. If you do not attend a scheduled appointment and do not call to cancel or reschedule (“no show”), you will be charged the full cost of posted fees. If you arrive late to your scheduled appointment you may not receive the full scheduled time, however you will be charged for the time booked.

*I understand the cancellation and no show policy \_\_\_\_\_\_\_\_\_****initials***

**Consent to Treatment (to be signed after assessment)**

Massage Therapy involves the manipulation of the soft tissues of the body, skin, muscle, ligaments and connective tissues, using techniques to produce therapeutic results.

With Massage Therapy, the client disrobes to their comfort level, and lies on a table between two sheets. Only the areas of the body being directly treated are uncovered at one time. If at any time you are uncomfortable with the pressure or technique being used, you can tell the therapist (i.e. to decrease or increase pressure, irritating, etc.) You can also stop the treatment at any time.

My medical history is true and I will tell my therapist if any part of the medical history changes during the course of my treatment.

*I have read and understand the form and give my consent to begin treatment.*

Client signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Parent/Guardian/Health custodian signature if applicable:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Therapist signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

The Health Information Custodian is *Laura Hild, RMT* who will retain you records confidentially

for the required period of time- 10 yrs from last visit.