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MULTI INTAKE FORM

(MASSAGE THERAPY, PHYSIO THERAPY, ACUPUNCTURE SERVICE, CHIROPRACTIC SERVICE)

All clients are required to write legibly and give their information with double asterisk/star (**) for legal purposes*

If there are any questions please ask an Office Administrator at the front desk.

Full Legal Name:** _____ **Care Card Number (PHN):**** ☐☐☐☐☐☐☐☐☐☐

Email:* _____ **Birth Date (m/d/y):**** _____

Address: _____ **Occupation:** _____

City: _____ **Employer:** _____

Postal Code: _____ **Family Doctor's Name:** _____

Cell Phone:** _____ **Family Doctor's Phone:** _____

Home Phone: _____ **Emergency Contact's Name:** _____

Work Phone: _____ **Emergency Contact's Phone:** _____

Legal Gender:* ☐ Female ☐ Male **Emergency Contact's Relation:** _____

How did you **HEAR ABOUT ROYAL TREATMENT THERAPEUTICS?**

☐ Co-Worker ☐ Friend ☐ Family ☐ Internet ☐ Neighborhood ☐ Previous Patient ☐ Others

Do you wish to receive **REMINDERS**? ☐ YES ☐ NO *If YES, then via:* ☐ Text ☐ Email ☐ Both

***I agree to grant Royal Treatment Therapeutics permission to send email messages about scheduled appointments, cancellations, bookings, promos, discounts, including marketing updates. I understand I may unsubscribe at any time.*

FOR ICBC MOTOR VEHICLE ACCIDENT (MVA) TREATMENT: *All ICBC rates are applied as of April 1, 2019*

**NOTE: Royal Treatment Therapeutics does not handle WorkSafe BC (WCB). We do not combine Direct Billing with ICBC.*
You may start treatments ONLY after:

- *If you have been in a recent motor vehicle accident, reported the claim and given by ICBC a claim number.*
- *ICBC **pre-authorizes treatments** for 3 months from your accident date: **12 Massage**, **12 Acupuncture**, **25 Chiropractic**, and **25 Physio Therapy**.*
- *For any **extension request**, we will require a Doctor's note to be sent to your adjuster.*
- *If at any point during your treatment you decide to acquire a lawyer then please inform us of this at your earliest availability.*
- *Any new clients with motor vehicle accidents occurring before April 1, 2019 will need to provide claim number, adjuster's information, and a recent Doctor's note.*

Service:	Initial Duration:	Initial Treatment ICBC pays:	Subsequent Time:	Subsequent Treatments ICBC pays:
Registered Massage Therapy	*45 mins*	*$112.23 ($107 + tax)*	*30 mins*	*$84 ($80 + tax)*
Physio Therapy	*60 mins*	*$250 (no tax)*	*30 mins*	*$79 (no tax)*
Acupuncture Service	*60 mins*	*$105 (no tax)*	*30 mins*	*$88 (no tax)*
Chiropractic Service		*$199*		*$53 (no tax)*

Is this treatment for an **ICBC CLAIM**? ☐ YES ☐ NO *If Yes, please sign ICBC Consent Form*

Date of Injury (MVA):** _____ Claim Number:** _____

ICBC Adjuster's Name:* _____ Lawyer's Name: _____

IF THE TREATMENT IS FOR ICBC, THEN CLIENTS NEED TO SIGN THE ICBC CONSENT FORM*

GENERAL HEALTH HISTORY QUESTIONNAIRE

Reasons for your TREATMENT:

What is the PRIMARY REASON for your visit today?** _____

When did you FIRST NOTICE any symptoms? _____

Have you experienced these symptoms before? _____

Is your condition getting: ○ Worse ○ Same ○ Better

Are your symptoms: ○ Constant ○ Irregular

What is your current stress level? ○ Low ○ Moderate ○ High

Is your present condition the result of a SINGLE TRAUMATIC EVENT? ○ Yes ○ No

If YES, please specify: _____

What other type of treatment, if any, have you received for this condition? Did it help?

_____

Please list all you are currently taking:

Known allergies: _____

Prescriptions (name and dosage): _____

Over the counter drugs (name and dosage): _____

Vitamins (name and dosage): _____

Supplements (name and dosage): _____

Rate your pain: (mark ✓ on the pain scale below)

○ No Pain Mostly 

○ Tolerable Pain 

○ Irritating Pain 

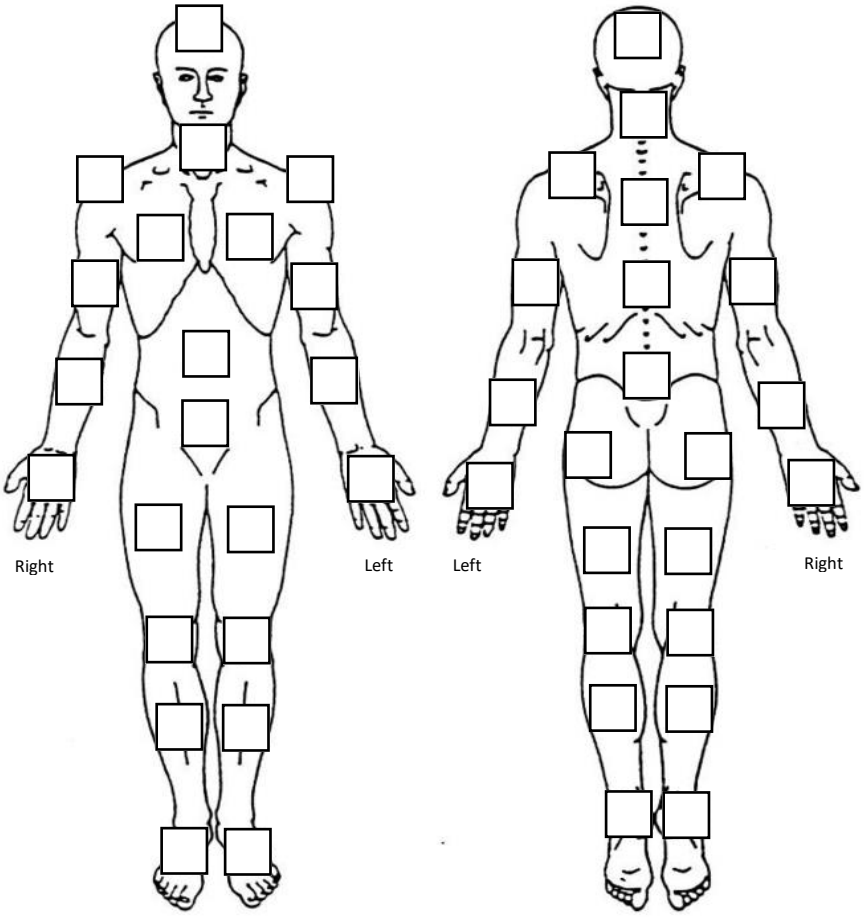
○ Hurts More Than Expected 

○ Hurts Very Much 

○ Requires Medical Attention 

BODY PAINS: (circle the area with problems and mark ✕ for WORSE area you want to be treated)

Using the body diagrams on the right, please mark areas in your body that hurts most.



Previous medical interventions:

○ X-ray ○ CT Scan ○ Injections

○ Surgery ○ Acupuncture ○ Others

If Others, please specify: _____

Others:

Currently pregnant? ○ YES ○ NO

Future pregnancy? ○ YES ○ NO

Body Implants? ○ YES ○ NO

If YES, please specify: _____

Mark which makes your condition: ✓ for BETTER, or ✕ for WORSE

○○ Bending	○○ Moving	○○ Medication	○○ In the Morning
○○ Sitting	○○ Standing	○○ Heat	○○ In the Evening
○○ Rising	○○ Walking	○○ Ice	○○ As day progresses
○○ Lying	○○ Changing Position	○○ Rest	○○ N/A

Have you EVER experienced or been diagnosed with any of the following conditions below? (mark ✓ to all that applies)

☐ AIDS/HIV/Hepatitis	☐ Diarrhea	☐ Kidney Disease	☐ Polycystic Ovary
☐ Alcohol Abuse	☐ Down Syndrome	☐ Lactose Intolerance	☐ Pregnant
☐ Anemia	☐ Drug Abuse	☐ Low Blood Pressure	☐ Psoriasis
☐ Arthritis	☐ Dwarfism	☐ Lupus	☐ PTSD
☐ Asthma	☐ Eating Disorders	☐ Memory Loss	☐ Scleroderma
☐ Autoimmune Disease	☐ Eating/Speaking Problem	☐ Menopause	☐ Scoliosis
☐ Bleeding Problems	☐ Eczema	☐ Mental Illness	☐ Shortness of Breath
☐ Broken Bones	☐ Endometriosis	☐ Migraine	☐ Sickle Cell Anemia
☐ Cancer	☐ Epilepsy/Seizures	☐ Mono (Nucleosis)	☐ Smoking
☐ Celiac Disease	☐ Fainting/Dizziness	☐ Motion Sickness	☐ Spina Bifida
☐ Cerebral Palsy	☐ Falling	☐ Multiple Sclerosis	☐ Spinal Cord Injury
☐ Bowel/Bladder Problem	☐ Fatigue	☐ Muscular Dystrophy	☐ Stroke
☐ Chronic Fatigue Syndrome	☐ Fever/Chills/Sweats	☐ Myofascial Pain	☐ Swallowing Problems
☐ Cleft Lip and palate	☐ Fibromyalgia	☐ Narcolepsy	☐ Thyroid Problems
☐ Constipation	☐ Gastroesophageal Reflux	☐ Nausea/Vomiting	☐ Tourette Syndrome
☐ Cough	☐ Growth Hormone Deficiency	☐ Night Pain	☐ Tuberculosis
☐ Crohn's Disease	☐ Heart diseases	☐ Numbness/Tingling	☐ Turner syndrome
☐ Cystic Fibrosis	☐ Heartburn/Indigestion	☐ Obesity	☐ Ulcerative colitis
☐ Deafness/Hearing Problem	☐ High Blood Pressure	☐ Obsessive Compulsive Disorder	☐ Ulcers
☐ Depression/Anxiety	☐ Huntington's Disease	☐ Osteoporosis	☐ Vision problems
☐ Diabetes	☐ Inflammatory Bowel Disease	☐ Pacemaker	☐ Weight Gain/Loss

Are there any OTHER CONDITIONS you have that is not listed above? Please list below:

Have you RECENTLY noticed any of the conditions above in the past month? Please list below:

Has anyone in your IMMEDIATE FAMILY been diagnosed with any of the conditions listed above? Please list below:

Is there ANY INFORMATION you want to share about your present condition that would help us? Please describe below:

What do you WISH TO GAIN after the end of the treatments?

TREATMENT CONSENT FORM

NOTE that you can:

- Ask your Therapist any questions you have about this form or its contents **BEFORE** you sign this document.
- Ask questions about your treatment at **ANYTIME**.
- Immediately advise your practitioner **IF YOU BECOME UNCOMFORTABLE** in any way with your treatment.

The **TREAMENT**:

***I authorize and understand that the practitioners may perform the following specific treatments on me:*

Soft Tissue Mobilization	Joint Mobilization	Exercise Therapy	Other
(for Massage, Chiro, Physio)	*(for Massage, Chiro, Physio)*	*(for Chiro, Physio)*	*(for Acupuncture)*

Instructions for **CLIENT SIGNATURE**:

All clients must INITIAL ON ALL THE BOXES BELOW *to indicate acknowledgement and understanding of each statement. Clients must sign this form of consent before any treatment for legal reasons.*

The Risks, Complications, and Side Effects of **MASSSAGE**, **PHYSIO**, **CHIRO**, and **ACUPUNCTURE** Treatment:

☐ I understand there are risks and complications that may arise with each individual case associated with treatment.
*Examples for **Massage**, **Physio**, and **Chiro**: bruising, aching, discomfort, short term aggravation of symptoms, and skin irritation. Examples for **Acupuncture**: minor bleeding, numbness or tingling at or near the needling sites that may last for a few days; light-headedness or dizziness may happen occasionally or even fainting very rarely; burns and scarring are potential risks of Moxibustion; bruising can occur after cupping or Gua Sha scraping treatment. Some symptoms may worsen at the beginning of treatment. If the symptoms worsen and persist for more than 2 days, please inform your Registered Acupuncturist. In very rare instances, spontaneous miscarriage and pneumothorax have been reported.*

☐ I acknowledge that while Massage, Physio, Chiro, and Acupuncture treatments, and other Traditional Chinese Medicine (TCM) modalities, have been proven to be highly effective in correcting a variety of disorders and maintaining overall well-being, I have been advised that all Registered Therapists in BC are required to advise patients of the potential risks and complication, but not limited to, the list above.

☐ I will discuss with my therapist the nature and purpose of the proposed treatments, the possible alternative methods of treatment, the risks involved and the possible complications and side effects.

☐ I will discuss my concerns about possible risks with my practitioner **AFTER** signing this document. If I develop a concern after signing, I agree to discuss with the Therapist immediately.

CONFIDENTIALITY, SHARING MEDICAL RECORDS and **COMMUNICATIONS** with my other Heath Care Professionals:

☐ I understand that my Therapists may review my medical records and lab reports if needed, but all my records will be kept strictly private and confidential at Royal Treatment Therapeutics and will not be released without my written consent. I can always revoke my consent in the future in writing.

☐ I understand at Royal Treatment Therapeutics that my Therapists can share my medical history and communicate with other health care professionals including ICBC adjusters and lawyers regarding my treatment or billing, if necessary. I can always revoke my consent in the future in writing.

Disclosure of **MEDICAL HISTORY**:

☐ I acknowledge that it is important for the Therapist to know my relevant medical history before treating me. Therefore the information disclosed and provided by me is true and complete, to the best of my knowledge.

☐ I have disclosed to the Therapist all medical conditions, including any mental or emotional conditions for which I have received treatment within the last 12 months or anything relevant over the years.

☐ I will disclose any new conditions that may develop after my completion of this form.

CONFIDENTIALITY:

☐ The contents of this form and my client records will be kept confidential unless I have expressed or implied consent to the release of my information or where there is a legal requirement to provide it to a third party.

No Guarantee of **RESULTS** and **CONSENT OF TREATMENT**:

☐ I acknowledge and confirm that no guarantees or assurances of results have been made to me regarding and of my treatments. I acknowledge that my practitioner is an independent contractor, professional, and legally responsible for the treatment plan delivered. I release Royal Treatment Therapeutics from any liability.

CANCELLATION POLICY:

☐ In consideration of other patients and my therapist, I understand that a minimum of **48 HOURS' NOTICE** is required to change or cancel my appointment**. I am aware that it is my responsibility to pay 100% of the treatment fee in the case of late cancellations or missed appointments.**

By signing below I understand and agree to all the statements previously outlined.

Client Signature**

Date Signed**

PARENT or **GUARDIAN CONSENT**:

In the case of a person incapable of providing consent, signature of Parent or Guardian is required:

Parent or Guardian Signature

Name of Parent or Guardian

Relationship to the Client

Please make sure the client's correct information, initials, and signatures are affixed on pages 1, 4, and 5*