Westcoast Forest Therapeutics Ltd.
1090 Howe St., Vancouver, BC V6Z 1P5
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Website: http://www.westcoastforestmassage.com

Registered Massage Therapy (RMT) Intake Form

Contact Information

Name: _____ Birthday: (YY/MM/DD) _____

Address: _____ City: _____ Postal Code: _____

Phone: (Home) _____ (Cell) _____ Email:_____

Occupation: _____ Work Phone: _____

Referred by: _____ ☐ Media; ☐ Pamphlet; ☐ Other: _____

Emergency Contact:_____ Tel: _____

Chief Complaint

What is your major complaint? _____

_____

Which treatment(s) are you currently using or have you tried for this health concern?

☐ Physician ☐ Physiotherapy ☐ Massage ☐ Acupuncture/TCM ☐ Chiropractor ☐ Others _____

Medical History (Please check if you have been diagnosed any of the following):

☐ Heart Disease	☐ Stroke	☐ Seizures	☐ High/Low Blood Pressure
☐ Lung Disease	☐ Asthma	☐ Allergies	☐ Dermatitis/Skin Problem
☐ Liver Disease	☐ Hepatitis	☐ Headache/Migraines	☐ Thyroid Disease
☐ Kidney Disease	☐ Diabetes	☐ Arthritis	☐ Bleeding Problem
☐ Vision Concern	☐ Cancer	☐ STD	☐ Menstrual Concern
☐ HIV/AIDS	☐ Others (specify): _____		

Do you have any allergies or sensitivity to any food or medications? ☐ No ☐ Yes

If yes, please list: _____

Do you exercise regularly? ☐ No ☐ Yes (specify): _____

**** Should you need to cancel or reschedule your appointment, we require at least 24 hours of notice to avoid being charged.**
**** No show or late cancellation (less than 24 hours) will result in a 50% non-refundable charge.**

I wish to rely on the health practitioner to exercise judgment during the course of treatment. I also understand that the results may vary and are not guaranteed; therefore, as such there is no refund for treatments.
I have read the above consent. By signing below, I agree to the health practitioner's treatment plan.

Signature of Patient/Client: _____ Date: _____

Signature of Registered Massage Therapist:_____

A Healthy Mind Needs A Healthy Body!