Momentum Health Patient Intake Form

NAME: _____ DATE: _____

DATE OF BIRTH: MMM / DD / YYYY AGE: _____ BC HEALTH CARE #:_____

ADDRESS: _____ POSTAL CODE:_____

CITY: _____ PHONE: _____

EMAIL: _____ May we contact you by email? YES or NO

Would you like to be set up for appointment reminders? YES - Email / Text / Both or NO Reminders

OCCUPATION: _____

Emergency contact: _____ Phone: _____

HOW DID YOU HEAR ABOUT OUR CLINIC? (please circle one)
Website Doctor (name:_____ Patient/Friend (name:_____) Walk-in
Other: _____

Do we have your permission to contact your family physician regarding coordination of your care? YES or NO
If yes, what is your family doctors name and location of practice? _____

PLEASE NOTE OUR LATE CANCELLATION/MISSED APPOINTMENT POLICY:
Momentum Health is committed to providing all of our patients with exceptional and timely care. We would appreciate 24 hours advance notice if you are unable to attend a scheduled appointment so we can attempt to fill the appointment time. Failure to do so may result in a **$50 missed appointment charge** payable prior to your next appointment being administered to your account.
I have read and agree to the above terms:_____ **(Initial)**

Is the reason you came to this office related to a:

A) Motor Vehicle Accident?	YES	NO	**Date of loss:** MM / DD / YYYY
B) Work-related injury (WCB)?	YES	NO	**Date of loss:** MM / DD / YYYY

When did your symptoms start? _____

Describe your symptoms and when they began: _____

_____

How often do you experience your symptoms?

- ☐ Constantly (76 - 100% of the day)
- ☐ Frequently (51 - 75% of the day)
- ☐ Occasionally (26 - 50% of the day)
- ☐ Intermittently (0 - 25% of the day)

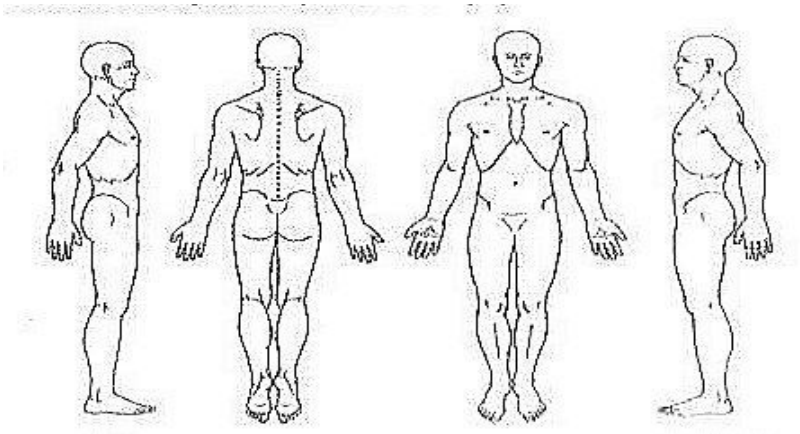
What describes the nature of your symptoms?

- ☐ Sharp
- ☐ Dull ache
- ☐ Numb
- ☐ Shooting
- ☐ Burning
- ☐ Tingling

How are your symptoms changing?

- ☐ Getting better
- ☐ Not changing
- ☐ Getting worse

Indicate where you have pain or other symptoms:



none ***unbearable***

How would you currently rate your symptoms? 0 1 2 3 4 5 6 7 8 9 10

How do your symptoms affect your ability to perform daily activities?

0	1	2	3	4	5	6	7	8	9	10
no complaints			*mild, forgotten with activity*		*moderate, interferes with activity*		*limiting, prevents full activity*		*intense, preoccupied with seeking relief*	*severe, no activity possible*

Who have you seen for your current symptoms? ☐ No one ☐ Medical Doctor ☐ Other ☐ Chiropractor ☐ Acupuncturist ☐ Massage Therapist

What activities make your symptoms worse? _____

What activities make your symptoms better? _____

What tests have you had for your symptoms and when were they performed?

☐ X-Ray: (date) ☐ MRI : (date) ☐ CT Scan: (date) ☐ Other: (date)

What type of regular exercise do you perform? _____

How has your sleep been? Before condition (Excellent/Good/Poor) **Since condition started?** (Excellent/Good/Poor)

For each of the conditions listed below, place a check in the *"Past"* column if you have had the condition in the past. If you presently have a condition listed below, place a check in the *"Present"* column.

Past	Present		Past	Present		Past	Present	
☐	☐	Headaches	☐	☐	High Blood Pressure	☐	☐	Diabetes
☐	☐	Neck Pain	☐	☐	Heart Attack	☐	☐	Excessive Thirst
☐	☐	Upper Back Pain	☐	☐	Chest Pains	☐	☐	Frequent Urination
☐	☐	Mid Back Pain	☐	☐	Stroke			
☐	☐	Low Back Pain	☐	☐	Angina	☐	☐	Smoking/use of tobacco products
☐	☐	Shoulder Pain	☐	☐	Kidney Stones	☐	☐	Allergies
☐	☐	Elbow/Upper Arm Pain	☐	☐	Kidney Disorders	☐	☐	Depression
☐	☐	Wrist Pain	☐	☐	Bladder Infection	☐	☐	Systemic Lupus
☐	☐	Hand Pain	☐	☐	Painful Urination	☐	☐	Epilepsy
			☐	☐	Loss of Bladder Control	☐	☐	Dermatitis/Eczema/Rash
☐	☐	Hip/Upper Leg Pain	☐	☐	Prostate Problems	☐	☐	HIV/AIDS
☐	☐	Knee/Lower Leg Pain						
☐	☐	Ankle/Foot Pain	☐	☐	Abnormal Weight Gain/Loss			
			☐	☐	Loss of Appetite	**Females Only:**		
☐	☐	Jaw Pain	☐	☐	Abdominal Pain			
			☐	☐	Ulcer	☐	☐	Birth Control
☐	☐	Joint Swelling/Stiffness	☐	☐	Hepatitis	☐	☐	Hormonal Replacement
☐	☐	Arthritis	☐	☐	Liver/Gall Bladder Disorder	☐	☐	Pregnancy
☐	☐	Rheumatoid Arthritis						
			☐	☐	Cancer			
☐	☐	General Fatigue	☐	☐	Tumor			
☐	☐	Dizziness	☐	☐	Asthma			
☐	☐	Visual Disturbances	☐	☐	Chronic Sinusitis			

Indicate if an immediate family member has had any of the following:

☐ Rheumatoid Arthritis ☐ Heart Problems ☐ Diabetes ☐ Cancer ☐ Lupus ☐ Other:

List all prescriptions and over-the-counter medications and nutritional/herbal supplements you are taking:

_____

List all the surgical procedures and hospitalizations:

Momentum Health Kelowna
103-1664 Richter Street
Kelowna, BC V1Y 8N3

INFORMED CONSENT TO MASSAGE THERAPY

THIS CLINIC MAKES EVERY EFFORT TO ENSURE THAT YOUR TREATMENT IS SAFE AND EFFECTIVE. IN PARTICULAR, YOU SHOULD NOTE:

a) Potentially painful treatments. Although some treatments may be painful, every effort is made to minimize the discomfort. Treatment can cease or be modified at anytime at the patient's request.

b) Removal of clothing. Only in the areas to be treated, is the removal of certain clothing preferred for effective treatment. It is the right of the patient to decline the removal of certain or any clothing. If the patient wishes, they have the option of bringing and wearing shorts and sports bra (for women) during their treatment.

c) Files. This clinic will be keeping all recorded information as part of your patient file. The collection, use and disclosure of personal information, as defined in the ***Personal Information and Privacy Act***, will only be used for treatment and or any related administrative purposes. If your file is ever needed in a legal matter, your file will not be released without your prior consent.

d) Cancellations, lateness, and "No Shows". "No Shows" and cancellations made less than 24hrs. prior to appointment time will be billed the **full amount.** Please note that we cannot bill insurance agencies for missed appointments. For the consideration of staff and other patients, please do not be late for your appointment. In the event you are late, we may be unable to accommodate your complete treatment time.

I acknowledge I have discussed, or have had the opportunity to discuss, with my Registered Massage Therapist the nature and purpose of massage therapy. I consent to the massage therapy treatment offered or recommended to me, by my Registered Massage Therapist. I intend this consent to apply to all my present and future massage therapy care.

Patient Full Name (please print): _____

Patient Signature: _____ Date: _____