John Forsyth RMT

2025 Confidential New Patient Intake Form

- All information protected by Law - BC PIPA.
- All Regulations of Ministry of Health apply.
- No WorkSafeBC/ Work-related injuries!
- All Clinic Polices apply.

Full legal Name: _____
_____
[*Guardian: _____]
Address*:_____
_____
City/Prov _____
Postal code: _____
E-Mail*: _____
Cell Phone + _____
Birth Date:_____
Gender*(circle one): M or F _____

----- Above required.----

If you are new to massage therapy? Y or N

How did you hear about our clinic?
_____

- ***All appointments and fees are solely patient's responsibility.*** Note 48-hour cancellation policy in effect. Neither the Clinic nor Insurance takes any responsibility for patient's missed appointments or fees. All balances should be reconciled in 24-hours.

Only as courtesy we may provide a 72-hour appointment notification by email and or text cell phone or email during account setup.

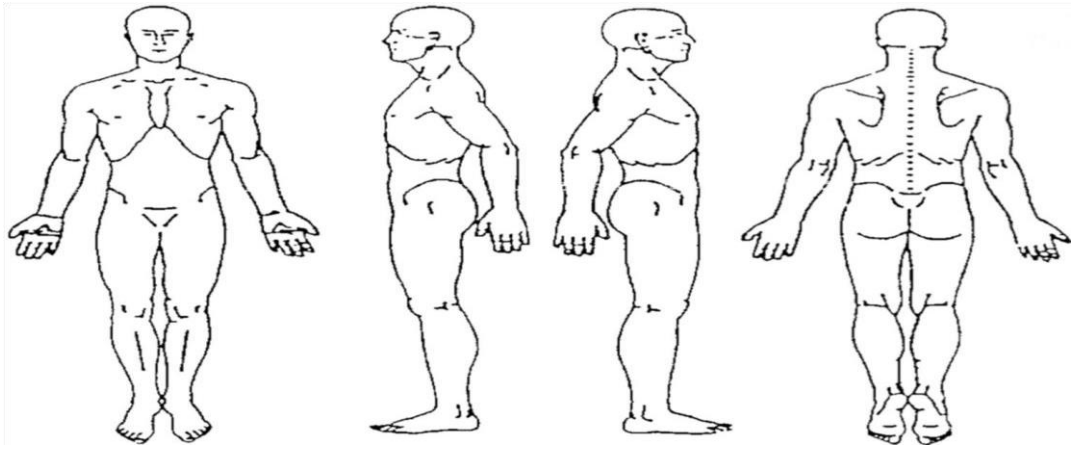
Reason for this appointment? (please, circle one of 3 choices below and explain):

(1) *personal choice*, (2) *MD Referral,* (3) MVA (ICBC)* (*** This clinic does not bill ICBC*).**

- **Explain (concern):** _____
- *(**ICBC: MVA date/#/adjustor):** _____

Your expectations for this treatment: _____

Describe your current condition, symptoms (areas of discomfort); and/or use the diagram below:
_____
_____



(over pg 2)

List any treatments, medications currently on/using:
_____

Please list any major accidents, illnesses or surgeries (especially within treatment region)

_____

_____

Please check any diagnosed/problematic and describe:

__ **Respiratory infections** _____
__ **Any contagious disease(s)** _____
__ **Brain, nervous system**: _____
__ **Immune system** _____
__ **GIT/Digestive** _____
__**Organs** _____
__**Blood/coagulation/bruising**: _____
__ **blood vessel/pressure**: _____
__ **Lungs/heart** _____
__ **Metabolic/diabetes** _____
__ **Skeletal, muscle, lig., bone** _____
__ **Psychology/anxiety** _____
__ **other?** _____
__ notes: _____

I, the patient, am at least 16 years old and have no known impediments to either my agency or capacity to make decisions about my health care; and,

I accept the following: all BC massage regulation, this Clinic's Policy and declaration of that all information provided - personal, medical and insurance is accurate, truthful and up to date to the best of my knowledge as the terms & conditions of (this) massage service; and,

I understand that I am opting for a non-essential medical treatment and assume all risks, known or unknown, as massage therapy involves maintaining prolonged and close physical contact within a confined space; thereby elevates the risk of disease transmission including COVID-19; and,

I assume all risks of this treatment; which include those side-effects of therapeutic touch such as temporary aggravation of the condition; and acknowledge that the RMT will treat in the most safe and effective manner but offers no guarantee of results; and,

I acknowledge that I will consult and formulate a treatment (plan) with the RMT for this and any future appointments when deemed necessary prior to any massage therapy commencing; and

furthermore, I confirm that the RMT has provided all information necessary that I can make "informed consent" to make the decision to make, continue, modify or terminate this and subsequent treatment(s) with this registered massage therapist, by my verbal consent or initials noted on the consultation portion of clinic form(s); and lastly,

I dismiss any claim of liability against the RMT and or the Clinic and accept of all terms & conditions of service and risks, including indebtedness for services rendered by my signature below and continuing with the massage service(s).

➢ _____ _____ , 2025

Signature* of patient / or parent/ Legal Guardian **Date**