**STUDENT HANDOUT** Module 2 of 7

Clinic 1 · Supervised Clinical Practice (RU-RMT-13)

# Client Intake, Health History & Informed Consent

*Gathering the story, earning consent — everything safe treatment is built on*

This handout accompanies the Module 2 lecture. It covers the client interview and health history, screening for safety, the CMTO standards that govern what you collect and how you communicate, and the law and practice of informed consent — including the special written-consent rules for sensitive areas. Most of what makes treatment safe and effective is decided before you lay on a hand.

## 1 · Learning outcomes

By the end of Module 2 you will be able to:

1. Conduct a professional, structured client interview and record an accurate, complete health history.
2. Collect only the personal health information necessary for safe, effective care.
3. Identify contraindications and red flags that modify, delay or preclude treatment.
4. Obtain informed consent that is informed, voluntary, capable, specific and ongoing.
5. Apply the written-consent requirement for sensitive areas and document consent correctly.
6. Communicate in plain language, with active listening and cultural safety, and protect confidentiality.

## 2 · Why intake matters

The interview is the most important part of the visit. Screening catches contraindications and red flags that change or stop treatment; the client's story and goals shape assessment and the plan; a calm, respectful interview builds the rapport the rest of the session depends on; and accurate intake is the foundation of a defensible clinical record. A repeatable intake sequence keeps you thorough: prepare (review any file, ready a private space, hand hygiene); greet and orient the client to the supervised teaching clinic; interview to gather the presenting concern

and relevant history; screen for contraindications and red flags; obtain informed consent; and document the history, screening and consent before you begin.

A repeatable intake sequence, step by step:

1. Prepare — review any existing file; ready the form and a private space; perform hand hygiene.
2. Greet and orient — introduce yourself and your student role; explain the supervised teaching-clinic setting and that care is observed and reviewed.
3. Interview — gather the presenting concern and a relevant health history using open, then focused, questions.
4. Screen — check for contraindications and red flags; decide whether to proceed, modify or refer.
5. Consent — explain the proposed assessment and treatment and obtain informed consent (written for any sensitive area).
6. Record — document the history, screening and consent before you begin.

## 3 · The clinical interview and health history

Start broad to hear the client's own words — “What brings you in today?”, “Tell me more about that” — then narrow with targeted questions. For each presenting concern, record its onset (how and when it began), location (primary and secondary areas), duration and frequency, radiation, intensity on a 0–10 scale, character (in the client's own words), aggravating and relieving factors, and any associated symptoms. Capture relevant past health, medications (including anticoagulants and dose), conditions (cardiovascular, diabetes/neuropathy, skin, neurological), pregnancy status, and the client's goals for the session. These map directly onto the Patient Interview & Intake section of your Treatment Record Form and become the Subjective portion of your SOAP note (Module 6).

Turn a complaint into recordable data you can re-test: rate pain at rest and on movement, map its location and any radiation on a body chart, note its pattern (constant, intermittent, activity-linked) and whether it is better, worse or unchanged since onset. Consistent, specific symptom data lets you measure change at reassessment and after treatment.

The dimensions you record for each presenting concern map field-by-field onto the intake section of your Treatment Record Form:

**Onset** — How and when the first episode began — e.g., gradual, ~3 weeks ago at a new desk job.

**Location** — Areas of primary and secondary concern — e.g., right upper trapezius; secondary mid-back.

**Duration & frequency** — How long each episode lasts and how often it occurs — e.g., daily by afternoon, easing overnight.

**Radiation** — Whether symptoms travel from the primary area to others.

**Intensity** — Discomfort/pain on a 0–10 scale, at rest and on movement.

**Character** — The client's own description of the sensation — e.g., a dull, tight ache.

**Aggravating / relieving factors** — What makes it worse and what eases it — e.g., worse at a desk; better with movement and heat.

**Associated symptoms & medication** — Anything accompanying the concern; medications including dose and OTC use.

#### Rapport and active listening

Communication that earns accurate information is a clinical skill. Sit at eye level, put devices away, and give the client your full attention. Let the client tell their story before you narrow with specific questions. Listen to understand rather than to reply; reflect and clarify to confirm you have understood and to show the client you are listening; and watch non-verbal cues — guarding, wincing and hesitation are data, and cues to check comfort and consent. Note the client's exact words for the record. A client who feels rushed or judged withholds information you may need for safety.

#### Past health, medications and lifestyle

Context keeps treatment safe. Ask about, and record, anything that changes pressure, positioning or technique:

**Conditions** — Cardiovascular disease, diabetes, neurological conditions and skin conditions may modify pressure and positioning.

**Surgeries and injuries** — Recent or relevant to the area being treated.

**Medications** — Anticoagulants (blood thinners) change technique and raise bruising risk; note the medication and dose.

**Pregnancy** — Trimester and any complications guide positioning and contraindicated areas.

**Sensation** — Neuropathy reduces the client's pressure feedback — moderate pressure and check the skin.

**Occupation and activity** — Postural load, repetitive tasks and stressors help explain the presentation and shape self-care.

## 4 · Communication

The client can only consent to what they understand. Use plain language, replace clinical terms with everyday words, and check understanding by asking the client to tell you back what they have agreed to. Arrange interpretation where needed rather than relying on a family member for clinical detail, and let a third party the client chooses assist with communication. Listen to understand, reflect and clarify, and stay non-judgemental — a client who feels judged withholds information you may need for safety. The full standard follows.

CMTO STANDARD OF PRACTICE

### Communication

*Approved Feb 9, 2021*

**Client outcome.** The client receives the information needed to make an informed decision and can ask questions of their RMT.

**RMT outcome.** The RMT clearly gives the client the information required to make informed decisions and communicates professionally.

#### What the standard requires

1. Obtain informed consent (the six elements) before assessment, treatment or plan changes.
2. Engage the client in dialogue so they can discuss goals, raise concerns, ask questions, participate in decisions and suggest changes.
3. Use effective communication — plain language and active listening — to convey information accurately.
4. Adapt communication to the client's understanding, needs and preferences.
5. Allow a third party chosen by the client to help with communication when requested.

6. Keep all communication — spoken, written (paper and electronic) and social media — respectful, ethical and professional, protecting privacy and confidentiality.

**Relevant legislation.** Health Care Consent Act, 1996; Personal Health Information Protection Act, 2004 (PHIPA).

**Career-Span Competencies.** Act with professional integrity · Apply the principles of sensitive practice · Communicate effectively · Comply with legal requirements.

*Cited: College of Massage Therapists of Ontario — "Communication", Standard of Practice / Guide. cmto.com/rules/standard-of-practice-communication*

### Cultural safety and inclusive intake

Every client is entitled to respectful, non-judgemental care free from discrimination on any ground protected by the Ontario Human Rights Code. Ask rather than assume — about preferences, comfort, language needs, pronouns and the areas a client is willing to have treated. Adapt your communication, use plain language, and confirm understanding. Respect the client's autonomy over their own body and care at every step, and practise cultural humility by noticing and setting aside your own assumptions. The Collecting PHI standard reinforces this: your questions must be sensitive and inclusive, and must never stigmatize the client.

## 5 · Collecting personal health information

More information is not safer information. The Collecting PHI standard — a new, client-centred requirement in effect since 1 November 2025 — sets out what you must ask, what you must never ask, and what you may ask using professional judgement. Before asking a sensitive question, ask yourself whether the answer changes how you will assess or treat; if not, do not collect it. Explain why you need sensitive details, and let the client decline.

CMTO STANDARD OF PRACTICE

### Collecting Personal Health Information from Clients

*Approved Mar 25, 2025; in effect Nov 1, 2025*

**Client outcome.** The client is asked to share only the PHI necessary for care and is protected from requests for unnecessary or sensitive information that could cause harm, stigmatization or discrimination. The client controls how their PHI is collected, used and disclosed.

**RMT outcome.** The RMT uses professional judgement and a client-centred approach to collect only the information necessary to provide safe and effective care.

### What the standard requires

7. Inform clients about collection practices and their right to give, withhold or withdraw consent to collection, use or disclosure of PHI.
8. Collect only information reasonably needed for safe, effective treatment.

9. Offer more than one collection option (verbal, written, electronic, or a combination) to meet different clients' needs.
10. Use a sensitive, inclusive approach that does not discriminate against or stigmatize the client.
11. Must ask for: name and contact/emergency details; physician and referring practitioner; date of birth/age, language and accessibility needs; history of massage care; updates since the last visit; information needed for an acute concern or referral; reason for seeking care; and allergies.
12. Must never ask about: information unrelated to safe, effective care (e.g., personal life); or risks already covered by routine infection-control practices (e.g., HIV/AIDS, Hepatitis C).
13. May ask, using judgement: stage of life (e.g., pregnancy); relevant conditions (skin, muscle, joint, bone, cardiovascular, respiratory, inflammatory); gender identity and pronouns; injuries; pain/pressure sensitivity; cancer status if voluntarily disclosed; physical symptoms of a mental-health condition (physical symptoms only); acute symptoms; and current relevant medications (analgesics, NSAIDs, anticoagulants, muscle relaxants, etc.).
14. Ask clarifying questions during the session when needed, and explain the reasons for collecting information when asked.

**Relevant legislation.** Massage Therapy Act, 1991 (Part III: Records); PHIPA, 2004.

**Career-Span Competencies.** Act with professional integrity · Function in a client-centred manner · Apply the principles of sensitive practice · Maintain comprehensive records · Comply with legal requirements.

*Cited: College of Massage Therapists of Ontario — "Collecting Personal Health Information from Clients", Standard of Practice / Guide. cmto.com/rules/collecting-personal-health-information-from-clients-standard*

## 6 · Screening: contraindications and red flags

Screen every client before you touch. Contraindications fall into types, and your action follows the type: an absolute contraindication means treatment is unsafe anywhere (do not treat; refer/escalate); a relative contraindication means treatment may be unsafe (modify; consult your supervisor); a local contraindication means one area must be avoided (treat elsewhere; avoid the site); and a conditional contraindication means treatment is safe only if conditions are met (confirm clearance or consent first). When uncertain whether a contraindication applies, stop and consult your supervisor before proceeding.

Red flags are signs that a presentation needs more than a massage. Stop and escalate for: unexplained weight loss, night pain or fever (possible systemic illness); new neurological signs

such as numbness, weakness, or loss of bladder or bowel control (urgent referral); severe, unremitting or worsening pain not typical of soft-tissue complaints; and recent significant trauma (rule out fracture before any treatment). Red flags are for referral, not diagnosis: describe what you observe and escalate.

A quick red-flag reference to keep in mind while you interview:

**Constitutional signs —** Unexplained weight loss, night sweats, fever or malaise — screen for systemic illness.

**Neurological signs —** Numbness, tingling, weakness, or any change in bladder or bowel control — urgent referral.

**Pain pattern —** Severe, unremitting, progressive or night pain that is not mechanical in nature.

**Trauma —** Recent significant trauma — rule out fracture or serious injury before any treatment.

**Vascular / cardiac —** Chest pain, breathlessness, calf pain or swelling — do not treat; refer.

#### Vitals and the pre-treatment baseline

Where indicated and available, record simple pre-treatment vitals — heart rate, respiratory rate and blood pressure — in the Pre-Tx vitals field of your Treatment Record Form, along with any diagnostic or imaging results the client reports. Taken consistently, these provide a baseline you can compare against after treatment, and they can flag values that warrant caution or referral. You will use and re-check these on Module 3 (assessment) and Module 4 (planning and reassessment).

*Contraindication screening draws on your Pathology and Health & Safety courses. Always err toward caution, and remember that the safe, professional outcome of a screen is sometimes to defer or refer rather than treat.*

## 7 · Informed consent

Consent is a continuing conversation, not a signature you collect once. A signed form is evidence of consent — it is not consent itself. Consent must be informed (the client understands what you propose, the benefits, material risks, alternatives, and the consequences of doing nothing), voluntary (given freely, mindful of the power differential), given by a capable client (or a substitute decision-maker), and specific and ongoing (reconfirmed whenever the

plan, area or technique changes). The client may pause, modify or stop at any time — and you stop immediately. CMTO requires the six elements of consent to be discussed, and consent conversations to be documented in the record within 24 hours.

CMTO STANDARD OF PRACTICE

## Consent

*Approved Feb 9, 2021*

**Client outcome.** The client receives the information they need to make an informed decision, can ask questions, and knows they may withdraw consent at any time. Care begins only after consent is given.

**RMT outcome.** The RMT obtains informed consent from the client or their substitute decision-maker before and throughout assessment and treatment.

**What the standard requires**

15. Before assessing, treating or modifying a plan, discuss the six elements of consent: the nature of the treatment; expected benefits; risks and side effects; alternatives; the likely consequences of no treatment; and the client's right to ask questions and to stop or change treatment at any time.
16. If the RMT lacks sufficient information about a modality or product's risks, benefits and contraindications, consent cannot be obtained and it must not be used.
17. Obtain written informed consent before every assessment/treatment of sensitive areas — upper inner thighs, chest-wall muscles and breasts. Breasts are touched only when the client requests it for a clinically indicated reason. Gluteal (buttock) consent may be written once per treatment plan, then verbal each visit.
18. Consent must relate to what is proposed, be voluntary, and not obtained through misrepresentation or fraud.
19. The client must be capable; if incapable, a substitute decision-maker may consent. If incapable with no substitute available, the RMT must not proceed.
20. Monitor the client throughout and reverify consent when appropriate.
21. Document consent conversations in the health record within 24 hours; keep written sensitive-area consent in the record.

**Relevant legislation.** Health Care Consent Act, 1996; O. Reg. 544/94 (incl. professional misconduct s.26) under the Massage Therapy Act, 1991.

**Career-Span Competencies.** Apply the principles of sensitive practice · Communicate effectively · Comply with legal requirements · Function in a client-centred manner · Maintain comprehensive records.

*Cited: College of Massage Therapists of Ontario — "Consent", Standard of Practice / Guide. cmto.com/rules/consent*

**Consent for sensitive areas**

The chest-wall musculature, breast tissue, inner thighs and gluteal region are sensitive areas. You must obtain **written** informed consent before assessing or treating the upper inner thighs, chest-wall muscles or breasts; breasts are touched only when the client requests it for a clinically indicated reason (for example, perinatal care or post-surgical rehabilitation), and never the nipples or areolae. Written consent for the gluteal muscles may be obtained once per treatment plan and then confirmed verbally each visit. The genital area and gluteal cleft are protected from exposure and never touched (explicit consent to expose them applies only during childbirth). Explain the reasons, benefits, risks and proposed draping, answer all questions, and record the written consent, the clinical justification and the draping used. CMTO's position on the treatment of sensitive areas stresses that a signed consent is not valid without ongoing informed consent obtained and recorded each time treatment is delivered, and that treatment must be discontinued once the treatment-plan goals for that area are met (CMTO, “Treatment of Sensitive Areas,” 2004). The Module 5 handout walks through Ruhani's Consent for Sensitive Areas form.

**Capacity and special situations**

Consent requires the capacity to understand the information and appreciate the consequences of the decision; capacity can vary with condition and time. Where a client is incapable, consent is obtained from the appropriate substitute decision-maker under the Health Care Consent Act, 1996; if a client is incapable and no substitute is available, you must not proceed. Follow CMTO and clinic policy for consent involving minors, and arrange interpretation to confirm genuine understanding. As a student, escalate any consent question to your supervisor.

**Documenting consent**

If it is not recorded, it is hard to defend. Note that you explained the assessment/treatment and that the client agreed; record written sensitive-area consent, the area, the clinical rationale and the draping; capture any change of plan and the fresh consent obtained; and if a client stops or declines, record what happened and what you did. CMTO requires consent conversations to be documented in the health record within 24 hours, and written sensitive-area consent to be kept in the record.

## 8 · Privacy and confidentiality

Client information is collected only for safe, effective care and protected at all times. Consent to handle personal health information (governed by PHIPA) is distinct from consent to treatment (governed by the Health Care Consent Act). Collect, use and disclose only what is necessary; share outside the circle of care only with consent or as required by law; store records securely; and never discuss clients outside the supervised clinic or on personal devices. Never make a categorical promise of absolute confidentiality — explain its limits honestly (consent, legal requirement, or a serious and imminent risk of harm), and escalate any disclosure question to your supervisor first.

CMTO STANDARD OF PRACTICE

### Privacy and Confidentiality

*Approved Feb 9, 2021*

**Client outcome.** The client's personal health information, privacy and confidentiality are securely protected.

**RMT outcome.** The RMT always maintains the privacy and confidentiality of clients and their personal health information.

**What the standard requires**

22. Comply with PHIPA, 2004, and understand that consent to handle PHI (PHIPA) differs from consent to treatment (HCCA).
23. For valid PHIPA consent: the client knows the purpose and that they may give or withhold consent; the consent relates to the information; and it is free of deception or coercion.
24. Obtain consent before disclosing PHI outside the circle of care; rely on implied consent within the circle of care unless the client has withdrawn it.
25. Obtain a substitute decision-maker's consent if the client is incapable.
26. Collect, use or disclose only the PHI necessary for the client's health needs or to reduce a significant risk of bodily harm.
27. Provide access only to authorized persons; allow clients to access their own information.
28. Discuss PHI only in ways that protect privacy — avoid treatment conversations in non-private areas.
29. Use electronic communication, social media and practice software ethically; secure data on personal devices.
30. Comply with mandatory reporting of privacy breaches.

31. Disable audio/video/photo recording in the room unless the client consents and it is for assessment, treatment or education.

**Relevant legislation.** PHIPA, 2004; O. Reg. 544/94 (professional misconduct s.26) under the Massage Therapy Act, 1991.

**Career-Span Competencies.** Act with professional integrity · Comply with legal requirements · Maintain comprehensive records · Interact effectively with other professionals.

*Cited: College of Massage Therapists of Ontario — "Privacy and Confidentiality", Standard of Practice / Guide. cmto.com/rules/standard-of-practice-privacy-and-confidentiality*

**Confidentiality in a teaching clinic**

Clients in a student clinic are observed and their care is reviewed — they must know and agree. Explain that this is a supervised teaching clinic, obtain the client's consent to be treated by a student and observed by a supervisor, and remember that a classmate's history and body are equally confidential within the learning setting. Release of a client's record to a third party requires the client's written, dated consent; if a consent is older than six months it should be refreshed before release (CMTO, "Release of Records").

## 9 · Difficult moments and common errors

**Disclosure of abuse or risk** — Stay calm, do not promise secrecy, and follow policy and your reporting obligations; involve your supervisor.

**Emotional distress** — Give space, respond with respect, and involve your supervisor if needed.

**A declined question or area** — Accept it without pressure, note it, and work with what you have.

**Leading questions** — Ask open questions first, then targeted ones; do not put words in the client's mouth.

**Assuming consent** — Confirm consent explicitly; a booking or a signature is not agreement to a specific technique or area.

**Collecting too much PHI** — Gather only what safe, effective care requires.

## 10 · Intake and consent checklist

Before you assess or treat, confirm that you have:

32. Introduced yourself and your student role and explained the supervised teaching-clinic setting.

33. Recorded the presenting concern and a relevant health history in the client's own words.
34. Screened for contraindications and red flags.
35. Collected only necessary PHI, explaining the purpose of sensitive questions.
36. Explained the proposed assessment and treatment (nature, benefits, risks, alternatives, consequences of no care).
37. Obtained informed consent — written for any sensitive area — and confirmed the client may stop at any time.
38. Documented the history, screening and consent (consent conversations within 24 hours).

## 11 · Worked example — intake to consent

A supervised first visit shows how the pieces fit together:

1. Story — the client reports a right-shoulder ache for three weeks, worse at a desk, no trauma and no red flags.
2. History — no relevant conditions or medications; the goal is to reduce the ache and move more comfortably.
3. Screen — no contraindications; a small skin abrasion is noted as a local caution, so that spot will be avoided.
4. PHI — only information relevant to safe care is collected; the reason for a question about medications is explained.
5. Consent — you explain the proposed assessment and relaxation/soft-tissue work; the client agrees; no sensitive areas are involved, so verbal informed consent is obtained and recorded.
6. Record — the history, screening, the client's goal and consent are documented before treatment begins.

## 12 · Key takeaways

39. The interview decides most of what makes treatment safe — do it well, every time.

40. Collect only the personal health information that safe, effective care requires (Collecting PHI standard, effective Nov 1 2025).
41. Screen every client for contraindications and red flags before you touch.
42. Consent is informed, voluntary, capable, specific and ongoing — and written for sensitive areas.
43. Document consent within 24 hours and protect confidentiality inside and outside the clinic.

## Standards & sources cited

*This handout draws on the following CMTO Standards of Practice, policies and legislation. Always consult the current text at cmto.com; standards are periodically revised.*

**CMTO — Consent (Standard)** — cmto.com/rules/consent

**CMTO — Communication (Standard)** — cmto.com/rules/standard-of-practice-communication

**CMTO — Collecting Personal Health Information from Clients (Standard, eff. Nov 1 2025)** — cmto.com/rules/collecting-personal-health-information-from-clients-standard

**CMTO — Privacy and Confidentiality (Standard)** — cmto.com/rules/standard-of-practice-privacy-and-confidentiality

**CMTO Policy — Treatment of Sensitive Areas (2004); Release of Records** — cmto.com

**Legislation — Health Care Consent Act, 1996; PHIPA, 2004; Massage Therapy Act, 1991** — ontario.ca

**Form — Ruhani College Treatment Record Form; Consent for Sensitive Areas** — internal