RUHANI COLLEGE
OF HEALTH BUSINESS AND TECHNOLOGY

RUHANI COLLEGE OF MASSAGE THERAPY

CLINIC 1 · RU-RMT-13

Client Intake, Health History & Informed Consent

Everything safe treatment is built on

MODULE	FOCUS	PROGRAM
02 of 07	Gathering the Story, Earning Consent	49 hours · 7 days

Aligned with the CMTO Standards of Practice & Code of Ethics, CMTCA accreditation standards, and the FOMTRAC Inter-Jurisdictional Practice Competencies (Entry-to-Practice).

RUHANI COLLEGE
OF HEALTH BUSINESS AND TECHNOLOGY

Recap & Bridge from Module 1

From professional foundation to the first client contact

Yesterday you set the professional, ethical and regulatory foundation. Today you make first contact with the client.

You know your scope. and the standards that govern every encounter.

You hold boundaries. and understand the power differential and consent in principle.

Now you gather the story. an accurate history and screen for anything that changes your plan.

And you earn consent. informed, voluntary and ongoing — before you assess or treat.

RUHANI COLLEGE
OF HEALTH BUSINESS AND TECHNOLOGY

Learning Outcomes

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

1. **Run a structured intake**
   Conduct a professional client interview and record an accurate, complete health history.

2. **Screen for safety**
   Identify contraindications and red flags that modify, delay or preclude treatment.

3. **Obtain informed consent**
   Apply the CMTO Consent standard, including written consent for sensitive areas.

4. **Collect PHI properly**
   Collect only necessary personal health information and protect it.

5. **Communicate clearly**
   Use plain language, active listening and culturally safe communication.

RUHANI COLLEGE
OF HEALTH BUSINESS AND TECHNOLOGY

Session Roadmap

How today unfolds

1. **The intake flow**
   Preparation, the interview, and structuring an accurate history.

2. **Screening & red flags**
   Contraindications and when to modify, delay or refer.

3. **Collecting PHI & communication**
   The CMTO standards that govern what you collect and how you talk.

4. **Informed consent**
   Elements, sensitive-area consent, capacity and documentation.

5. **Privacy & practice**
   Confidentiality, the record, and peer-practice intake.

Why Intake Matters

The interview is the most important part of the visit

Most of what makes treatment safe and effective is decided before you lay on a hand.

Safety. Screening catches contraindications and red flags that change or stop treatment.

Direction. The client's goals and story shape assessment and the plan.

Trust. A calm, respectful interview builds the rapport the rest of the session depends on.

The record. Accurate intake is the foundation of a defensible clinical record.

RUHANI COLLEGE
OF HEALTH BUSINESS AND TECHNOLOGY

The Intake Flow

A repeatable sequence for every client

1. **Prepare**
   Review any existing file; ready the form and a private space; wash your hands.
2. **Greet & orient**
   Introduce yourself and your student role; explain the supervised teaching-clinic setting.
3. **Interview**
   Gather the presenting concern and a relevant health history using structured questions.
4. **Screen**
   Check for contraindications and red flags; decide whether to proceed, modify or refer.
5. **Consent**
   Explain your proposed assessment and treatment; obtain informed consent.
6. **Record**
   Document the history, screening and consent before you begin.

RUHANI COLLEGE
OF HEALTH BUSINESS AND TECHNOLOGY

Preparing for the Interview

Set the client up to tell you the truth

1. **Privacy**
   Conduct intake where the conversation cannot be overheard; protect the client's dignity.

2. **Presence**
   Sit at eye level, put devices away, and give the client your full attention.

3. **Purpose**
   Explain what you'll ask, why, and that they can decline any question or area.

4. **Pace**
   Let the client tell their story before you narrow with specific questions.

RUHANI COLLEGE
OF HEALTH BUSINESS AND TECHNOLOGY

Communication

CMTO · Communication

Principle. The therapist communicates clearly, respectfully and effectively so the client understands and can participate in their own care.

WHAT THE STANDARD REQUIRES

- ◯ Use clear, plain, jargon-free language
- ◯ Confirm the client understands and is understood
- ◯ Communicate respectfully and without discrimination
- ◯ Adapt to language, culture and communication needs
- ◯ Communicate honestly with clients and the care team

WHAT IT MEANS FOR YOU AS A STUDENT

- ◯ Explain findings and plans in everyday words
- ◯ Check back: 'Does that make sense? Any questions?'
- ◯ Arrange interpretation rather than guessing
- ◯ Never rush or talk over a client
- ◯ Match your communication to this client

The Clinical Interview

Open the door, then narrow the focus

Start broad to hear the client's own words, then use targeted questions to complete the picture.

OPEN QUESTIONS FIRST

“What brings you in today?” let the client lead

“Tell me more about that” invite the full story

Silence give space to answer fully

Reflect back “So the pain is worse at night?”

THEN FOCUS

Onset & mechanism how and when it began

Location & radiation where, and where it travels

Character & intensity quality and 0–10 scale

Aggravating / relieving what worsens and eases it

RUHANI COLLEGE
OF HEALTH BUSINESS AND TECHNOLOGY

Rapport & Active Listening

Communication that gets accurate information

1. **Listen to understand**
   Not just to reply. Let the client finish; note their exact words for the record.

2. **Reflect and clarify**
   Paraphrase to confirm you've understood, and to show the client you're listening.

3. **Watch non-verbals**
   Guarding, wincing and hesitation are data — and cues to check comfort and consent.

4. **Stay non-judgemental**
   A client who feels judged withholds information you may need for safety.

Cultural Safety & Plain Language

Intake that every client can participate in

The client can only consent to what they understand.

Plain language. Replace clinical terms with everyday words; define anything technical.

Check understanding. Ask the client to tell you back what they've agreed to.

Language access. Arrange interpretation where needed; don't rely on a family member for clinical detail.

Respect. Ask about comfort, preferences and areas the client is willing to have treated.

A Complete Health History

What the history must capture

1. **Presenting concern**
   the primary and secondary complaint
2. **History of concern**
   onset, course, prior episodes
3. **Past medical history**
   conditions, surgeries, injuries
4. **Medications**
   prescription, OTC, supplements
5. **Red-flag screening**
   systemic and serious-pathology signs
6. **Lifestyle & occupation**
   posture, activity, stressors
7. **Cardiovascular / skin**
   for pressure & local cautions
8. **Goals & expectations**
   what the client wants today

The Presenting Concern in Detail

Structured questioning for each complaint

These map directly to the Patient Interview section of your Treatment Record Form.

DIMENSION	WHAT YOU ASK / RECORD
Onset	How and when the first episode began
Location	Area(s) of primary and secondary concern
Duration & frequency	Length of each episode; how often it occurs
Radiation	Whether it travels from the primary area
Intensity	Discomfort / pain on a 0–10 scale
Character	The client's own description of the sensation
Aggravating / relieving	What makes it worse; what eases it
Associated symptoms	Anything accompanying the concern

Past Health, Medications & Lifestyle

Context that keeps treatment safe

ASK ABOUT

Conditions cardiovascular, diabetes, neurological, skin

Surgeries & injuries recent or relevant to the area

Medications including blood thinners and dose

Pregnancy trimester and any complications

WHY IT MATTERS

Pressure & positioning conditions may modify both

Bruising & bleeding blood thinners change technique

Sensation neuropathy affects pressure feedback

Referral some findings need medical clearance

Pain & Symptom Assessment

Turning a complaint into recordable data

Consistent, specific symptom data lets you measure change at reassessment and after treatment.

RATE & MAP

0–10 scale record intensity at rest and on movement

Body chart mark location and any radiation

Pattern constant, intermittent, or activity-linked

Change better, worse or the same since onset

CHARACTERISE

Quality aching, sharp, burning, tingling, stiff

Timing worse in the morning, at night, at work

Triggers positions or activities that provoke it

Relief rest, heat, movement, medication

Contraindications

Screen before you touch

When uncertain whether a contraindication applies, stop and consult your supervisor before proceeding.

TYPE	MEANING	YOUR ACTION
Absolute	Treatment is unsafe anywhere	Do not treat; refer / escalate
Relative	Treatment may be unsafe	Modify; consult supervisor
Local	One area must be avoided	Treat elsewhere; avoid the site
Conditional	Safe only if conditions met	Confirm clearance / consent first

Contraindication screening draws on Pathology 1 and Health & Safety. Always err toward caution.

Red Flags — Stop and Escalate

Signs that need more than a massage

1. **Unexplained weight loss, night pain or fever**
   Possible systemic illness — refer for medical assessment.

2. **New neurological signs**
   Numbness, weakness, loss of bladder/bowel control — urgent referral.

3. **Severe, unremitting or worsening pain**
   Not typical of soft-tissue complaints — do not treat over it.

4. **Recent significant trauma**
   Rule out fracture or serious injury before any treatment.

Red flags are for referral, not diagnosis. Describe what you observe and escalate to your supervisor.

Collecting Personal Health Information

CMTO · Collecting Personal Health Information from Clients *· Effective 1 November 2025*

Principle. The therapist collects only the personal health information necessary for safe, effective, client-centred care.

WHAT THE STANDARD REQUIRES

- ◯ Collect only what is necessary for care
- ◯ Collect directly from the client where possible
- ◯ Tell the client the purpose of collection
- ◯ Obtain consent to collect the information
- ◯ Keep the information accurate and secure

WHAT IT MEANS FOR YOU AS A STUDENT

- ◯ Don't ask for detail you don't clinically need
- ◯ Explain why each sensitive question is asked
- ◯ Let the client decline a question or area
- ◯ Record only what supports safe care
- ◯ This standard took effect 1 Nov 2025 — know it

Collect Only What You Need

Data minimisation in intake

More information is not safer information — collect what safe, effective care actually requires.

Purpose test. Before asking, ask yourself: does this change how I assess or treat?

Direct collection. Gather information from the client, not from third parties, wherever possible.

Transparency. Tell the client why you need sensitive details; they may decline.

Security. Whatever you collect, you are responsible for protecting.

Consent

CMTO · Consent

Principle. The therapist obtains the client's informed consent before assessment and treatment, and treats only while consent is maintained.

WHAT THE STANDARD REQUIRES

- Consent must be informed, voluntary and current
- The client must have capacity to consent
- Explain assessment, treatment, risks & alternatives
- Written consent before sensitive-area work
- Consent may be withdrawn at any time

WHAT IT MEANS FOR YOU AS A STUDENT

- Never assume consent from silence or a signature
- Re-confirm consent whenever the plan changes
- Stop the moment a client asks you to
- Get written consent before any sensitive area
- Document what was consented to, and when

The Elements of Informed Consent

All must be present

1. **Informed**
   The client understands what you propose, why, the expected benefits, material risks and reasonable alternatives — including doing nothing.

2. **Voluntary**
   Given freely, without pressure — mindful of the power differential between therapist and client.

3. **Capable**
   The client can understand the information and appreciate the consequences of the decision.

4. **Specific & ongoing**
   Consent is for this assessment/treatment and is reconfirmed whenever the plan, area or technique changes.

Consent Is a Conversation

Not a signature you collect once

A signed form is evidence of consent — it is not consent itself.

Before. Explain what you'll do and why; invite questions; confirm agreement.

During. Check in as you move to new areas or increase pressure.

On change. Any change of plan, area or technique needs fresh agreement.

Anytime. The client can pause, modify or stop — and you respect it immediately.

Consent for Sensitive Areas

A written, explicit requirement

1 **What counts as sensitive**

Areas such as the chest/breast, gluteal region, upper inner thigh — as defined by CMTO — require special care.

2 **Written consent first**

Obtain written informed consent before assessing or treating a sensitive area, with clear clinical justification.

3 **Explain and offer alternatives**

Describe exactly what you'll do, why it helps, and that the client may decline or stop.

4 **Document specifics**

Record the area, the rationale, that written consent was obtained, and any draping used.

See the CMTO Consent and Professional Boundaries standards for the current definition and requirements.

Consent & the Power Differential

Voluntariness is fragile

Clients may agree because you are the expert and they feel vulnerable — that is not free consent.

Reduce pressure. Make it genuinely easy to say no; offer options rather than instructions.

Normalise stopping. Tell every client up front they can stop or modify at any time.

Watch for reluctant yes. Hesitation or guarding may mean 'no' — check before proceeding.

Never persuade. Consent obtained by pressure is not valid consent.

RUHANI COLLEGE
OF HEALTH BUSINESS AND TECHNOLOGY

Capacity & Special Situations

When consent needs extra care

1. **Capacity**
   Consent requires the ability to understand and appreciate the decision; capacity can vary with condition and time.

2. **Minors**
   Follow CMTO and clinic policy on consent for minors and the role of a parent or guardian.

3. **Substitute decision-makers**
   Where a client cannot consent, consent is obtained from the appropriate substitute decision-maker per law.

4. **Language & comprehension**
   Arrange interpretation; confirm genuine understanding before accepting consent.

Apply your program's policy and the current CMTO guidance to these situations; consult your supervisor.

RUHANI COLLEGE
OF HEALTH BUSINESS AND TECHNOLOGY

Documenting Consent

If it isn't recorded, it's hard to defend

1. **Record the discussion**
   Note that you explained the assessment/treatment and the client agreed.

2. **Note sensitive-area consent**
   Record written consent, the area, the rationale, and draping.

3. **Capture changes**
   Document any change in plan and the fresh consent obtained.

4. **Withdrawal**
   If a client stops or declines, record what happened and what you did.

RUHANI COLLEGE
OF HEALTH BUSINESS AND TECHNOLOGY

Privacy & Confidentiality

CMTO · Privacy and Confidentiality

Principle. The therapist protects clients' personal health information and collects, uses and discloses it only as permitted by law and with consent.

WHAT THE STANDARD REQUIRES

- ◯ Keep all client information confidential
- ◯ Use and disclose PHI only with consent or by law
- ◯ Store records securely; control access
- ◯ Retain and dispose of records appropriately
- ◯ Respect the client's right to access their record

WHAT IT MEANS FOR YOU AS A STUDENT

- ◯ Never discuss clients outside the clinic
- ◯ Don't leave files or screens visible
- ◯ No client photos or posts on personal devices
- ◯ Share with the care team only with consent
- ◯ Know your clinic's storage and retention rules

Protecting the Record

Confidentiality in practice

PAPER RECORDS

Store in a locked, access-controlled location

Carry only what's needed; never leave unattended

Dispose by secure shredding, never open bins

Display keep charts turned away from view

ELECTRONIC RECORDS

Access log in as yourself; never share passwords

Screens lock when away; angle from public view

Transmit only through approved, secure channels

Devices no client data on personal phones

The Limits of Confidentiality

When disclosure is required or permitted

1. **With consent**
   You may share information when the client has consented to the disclosure.

2. **Required by law**
   Certain situations (e.g. legal orders, mandatory reporting) require or permit disclosure.

3. **Risk of serious harm**
   Disclosure may be permitted to prevent a serious and imminent risk — follow law and policy.

4. **Tell your supervisor first**
   As a student, escalate any confidentiality question before disclosing anything.

Never make a categorical promise of absolute confidentiality; explain its limits honestly.

Confidentiality in a Teaching Clinic

Observation needs its own consent

Clients in a student clinic are observed and their care is reviewed — they must know and agree.

Disclose the setting. Explain that this is a supervised teaching clinic and care is observed and reviewed.

Obtain consent to observe. Clients consent to being treated by a student and observed by a supervisor.

Peers are clients too. A classmate's history and body are confidential within the learning setting.

No outside sharing. Never discuss a peer-client or client outside the supervised context.

Communication — Do & Avoid

On the floor and in the interview

DO

Introduce yourself & role as a student in a supervised clinic

Use plain language and confirm the client understands

Invite questions and answer honestly or escalate

Note the client's own words for an accurate record

AVOID

Medical jargon without explaining it

Assuming understanding always check back

Talking over the client let them finish

Making promises about outcomes or confidentiality

RUHANI COLLEGE
OF HEALTH BUSINESS AND TECHNOLOGY

Difficult Moments in Intake

Handling them professionally

1. **Disclosure of abuse or risk**
   Stay calm, don't promise secrecy, and follow policy and your reporting obligations.

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

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

4. **A request outside scope**
   Explain your limits honestly and refer or escalate.

RUHANI COLLEGE
OF HEALTH BUSINESS AND TECHNOLOGY

Practising Intake on Peers

Today's simulation

1. **Full professional intake**
   Run the complete interview on a classmate as if they were a member of the public.

2. **Real consent, real draping**
   Obtain consent and protect privacy exactly as you would with a client.

3. **Chart it**
   Complete the intake and consent sections of the Treatment Record Form.

4. **Debrief**
   Give and receive feedback on rapport, structure, screening and consent.

RUHANI COLLEGE
OF HEALTH BUSINESS AND TECHNOLOGY

Common Intake Errors

And how to avoid them

1. **Leading questions**
   ask open questions first
2. **Skipping red-flag screening**
   screen every client
3. **Assuming consent**
   confirm it explicitly
4. **Collecting too much PHI**
   only what care needs
5. **Charting from memory later**
   record promptly
6. **Missing the client's goal**
   ask what they want
7. **No sensitive-area consent**
   written, before you start
8. **Overpromising outcomes**
   be honest and realistic

Worked Example — Intake to Consent

A supervised first visit

1. **Story**
   Client reports right-shoulder ache for 3 weeks, worse at a desk, no trauma, no red flags.

2. **History**
   No relevant conditions or medications; goal is to reduce ache and move more comfortably.

3. **Screen**
   No contraindications; local caution over a small skin abrasion — avoid that spot.

4. **Consent**
   Explain proposed assessment and relaxation/soft-tissue work; client agrees; no sensitive areas.

5. **Record**
   Document history, screening, the client's goal and consent before beginning.

RUHANI COLLEGE
OF HEALTH BUSINESS AND TECHNOLOGY

Intake & Consent Checklist

Before you assess or treat

STEP	CONFIRMED?
Introduced yourself and your student role	☐
Explained the supervised teaching-clinic setting	☐
Recorded presenting concern and relevant history	☐
Screened for contraindications and red flags	☐
Collected only necessary PHI, with purpose explained	☐
Explained proposed assessment and treatment	☐
Obtained informed consent (written if sensitive area)	☐
Documented history, screening and consent	☐

Intake Feeds the Record

A preview of Module 6

Everything you gather today lands in the Treatment Record Form you'll master on Module 6.

Subjective. The interview and history become the Subjective section of your notes.

Consent fields. Informed consent and sensitive-area consent are recorded explicitly.

Screening. Contraindications and precautions inform your clinical impression.

Continuity. Accurate intake makes reassessment and future visits safer.

RUHANI COLLEGE
OF HEALTH BUSINESS AND TECHNOLOGY

Accreditation Alignment

Mapping Module 2 to FOMTRAC competencies

1 **PC 1**
Practises within legislated scope, ethics and standards

2 **PC 3**
Gathers and records client health information

3 **PC 4**
Obtains informed consent throughout care

4 **PC 3**
Communicates clearly, respectfully, safely

5 **PC 6**
Protects client privacy and confidentiality

6 **CMTCA**
Consent, PHI & communication standards met

CMTO Standards of Practice are published at cmto.com; students consult the current text directly. PC references follow the FOMTRAC Inter-Jurisdictional Practice Competencies.

RUHANI COLLEGE
OF HEALTH BUSINESS AND TECHNOLOGY

Key Takeaways

What to carry onto the clinic floor

1. The interview decides most of what makes treatment safe — do it well, every time.
2. Screen every client for contraindications and red flags before you touch.
3. Consent is informed, voluntary, ongoing and revocable — and written for sensitive areas.
4. Collect only the personal health information that safe, effective care requires.
5. Protect confidentiality inside and outside the clinic — including for peer-clients.

MODULE 02 COMPLETE

With the client's story gathered and consent secured, you're ready to assess.

Up next ·

Clinical Assessment & Clinical Reasoning

Module 3 turns your history and consent into structured assessment — observation, range of motion and palpation — and the clinical reasoning that turns findings into a safe plan.