Health History Form

The information request below will assist us in treating you safely. Feel free to ask any questions about the information being requested. Please note that all information provided below will be kept confidentially unless allowed or required by law. Your written permission will be required to release any information.

Name: _____ Phone # _____
Address:_____
Occupation:_____ Date of Birth: _____
Have you received massage therapy before? □ Yes □ No
Did a health care practitioner refer you for massage therapy? □ Yes □ No
If yes, please provide their name and address. _____
_____

Please indicate conditions you are experiencing or have experienced:

Cardiovascular
- □ high blood pressure
- □ low blood pressure
- □ chronic congestive heart failure
- □ heart attack
- □ phlebitis / varicose veins
- □ stroke/CVA
- □ pacemaker or similar device
- □ heart disease

is there a family history of any of the above? □ Yes □ No

Respiratory
- □ chronic cough
- □ shortness of breath
- □ bronchitis
- □ asthma
- □ emphysema

is there a family history of any of the above? □ Yes □ No

Infections
- □ hepatitis
- □ skin conditions
- □ TB
- □ HIV
- □ herpes

Other Conditions
- □ loss of sensation, where? _____
- □ diabetes, onset: _____
- □ allergies/hypersensitivity to what? _____ type of reaction: _____
- □ epilepsy
- □ cancer, where? _____
- □ skin conditions, what? _____
- □ arthritis

is there a family history of arthritis? □ Yes □ No

Head/Neck
- □ history of headaches
- □ history of migraines
- □ vision problems
- □ vision loss
- □ ear problems
- □ hearing loss

Women
- □ pregnant, due:_____
- □ gynaecological conditions, what?_____

Overall, how is your general health?
_____

Primary Care Physician:
_____
Address:
_____

_____

Current Medications:
_____
condition it treats: _____
_____

Are you currently receiving treatment from another health care professional? □ Yes □ No
If yes, for what? _____
_____

Surgery – date _____
nature: _____

Injury – date _____
nature: _____

Do you have any other medical conditions? (e.g. digestive conditions, haemophilia, osteoporosis, mental illness) □ Yes □ No
what? _____

Do you have any internal pins, wires, artificial joints or special equipment ? □ Yes □ No
what? _____
where? _____

What is the reason you are seeking massage therapy? Please include the location of any tissue or joint discomfort.
_____
_____
_____

Notes:

Date of initial Health History:_____
Update 1 _____
Update 2 _____
Update 3 _____
Update 4 _____

Informed Consent for Massage Therapy

Please read the following thoroughly. If you have any questions, please ask for clarification. While you are a client at this clinic, it is essential that you are aware of office procedures, treatment procedures and your rights.

Your Rights as a Client

- Treatment will only be provided when there is a reasonable expectation that it will be advantageous to you
- You have the right to refuse, modify or terminate treatment at any given time, regardless of prior consent
- Only the areas being treated will be undraped. Draping provides a physical boundary that ensures your, safety, comfort and privacy
- If any of the following areas (inner thighs, glutes/buttock, abdomen and breast) are to be included into treatment, the treatment procedures will be discussed. Additional consent will also be given prior to undraping/treating these areas
- If the Massage Therapist deems a referral to another healthcare provider is necessary, this will be done with the client's consent
- All administration staff adheres to a strict patient confidentiality code. Your privacy is of the utmost importance and your personal and private information will not be disclosed or shared

Treatment Procedure

All of the following will be discussed and agreed upon by the client and the RMT

- Needs, assessment and treatment plan including: client health history form, assessment and examination procedures, treatment modalities, self care, remedial exercise suggestions and frequency/duration of treatment
- Disrobing and draping requirements and methods
- Any potential risks, benefits and alternatives to proposed treatment plan

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Clinic Policies

- Fee schedules are posted in the clinic. NSF cheques are subject to a $25 fee
- Please noticy the clinic or RMT at least **24 hours** in advance to cancel an appointment, otherwise a **$25.00** fee will be charged for a missed appointment
- The RMT has the right to refuse of stop treatment if there is a reasonable cause

I have read and fully understand all information included in this form. I acknowledge that my consent is voluntary and I understand that I may withdraw my consent at any time prior to and/pr during treatment. I hereby consent to participate in this therapeutic relationship.

Patient: _____ **Therapist: _____**

Date: _____ **Date: _____**

_____