Patient Health History Form

First Name	Last Name

Phone Number	Email

Preferred Contact Method	Date of Birth (MM/DD/YYYY)

Are you taking any medications currently?

Have you had any recent surgeries?

Please check all boxes that apply to you below

Cardiovascular

- ○ High blood Pressure
- ○ Low blood pressure
- ○ Heart disease
- ○ Phlebitis
- ○ Pacemaker or similar device
- ○ Stroke/ CVA

Respiratory

- ○ Chronic cough
- ○ Shortness of breath
- ○ Bronchitis
- ○ Asthma
- ○ Emphysema

Infections

- ○ Hepatitis
- ○ Skin conditions
- ○ HIV/ Herpes
- ○ TB

Head/ Neck

- ○ History of headaches/ migraines
- ○ Vision loss/ problems
- ○ Hearing loss/ problems

Pregnant? How many weeks/ months?

Other Conditions

- O Diabetes
- O Epilepsy
- O Poor circulation
- O Fibromyalgia

Soft Tissue/ Joints

- O Arthritis/ Bursitis/ DDD
- O Swelling
- O Weakness
- O Herniated Disc/ Bulging Disc
- O Strain/ Sprain

Cancer (where)

Loss of sensation (where)

Business Policies

Cancelation policy/ No Show policy

We understand that there are times that you must miss an appointment, due to emergencies, work or family obligations. However, when you do not call and cancel an appointment you may be preventing another patient to get much needed treatment. ****If an appointment is not cancelled at least 24 hours in advance of your appointment you will be charged a 25 dollar fee, that will not be covered by your insurance.**

I have read and understand the above information, policies and consent and agree to abide by these conditions. If I have any questions or concerns I will notify the therapist know right away.

Patient Name (please print)_____

Patient Signature_____

Parent/ Gaurdian Signature (if under 18)_____

Date_____

Informed Consent Form

I, (Client's Name)_____ have chosen to consult with and hereby give consent for massage therapy to be provided by Tiffany Arsenault, who I understand is a member of the Association of Massage Therapy Association of Nova Scotia.

At any point during the massage treatment I am uncomfortable or uneasy with the procedure being administered and/ or I experience pain, I understand that it is my responsibility to immediately inform the massage therapist, so that procedures may be modified for patient comfort or terminated. I have the right to stop or modify the treatment at any time.

Sexual advances of any kind will not be tolerated.

I have provided a recent detailed medical health history and will inform the therapist if any changes occur. I do not expect the therapist to have foreseen any previous or pre-existing conditions that I have not mentioned.

I understand massage therapy may provide benefits for certain conditions but the results are not guaranteed. These benefits may include: decrease in muscle hypertonicity, sympathetic nervous system firing, reduction in symptoms related to chronic stress conditions, increase, relaxation and circulation.

I understand that massage may produce side effects such as muscle tenderness or soreness, decrease in muscle tone, mild/ slight bruising, light headedness and dizziness.

For patients under the age of 18, we ask for a parent/ guardian to be present for the signing of consent form. Patent/ guardian does not have to attend the treatment or stay on the premises but has the choice to do so.

Privacy policy

This practice is committed to the privacy of its clients. Personal information is kept confidential and will only be used for the prepose in which it was collected. Confidential information is kept on file and will not be released to third party without the consent of client or required by law.

I have read and understand the above information, policies and consent and agree to abide by these conditions. If I have any questions or concerns I will notify the therapist know right away.

Patient Signature_____

Parent/ Gaurdian Signature_____

Date_____