Health History Form

The information below will assist in treating you safely and help the Massage Therapist determine a proper treatment plan. Feel free to ask any questions about the information being requested. Please note that all information provided will be kept confidential unless allowed or required by law. Your written permission will be required to release any information.

Personal Information

Name: _____ Date of Birth: (m) _____(d)_____(y)_____

Address:_____ City: _____ Postal Code:_____

Telephone #:_____ Alt.Tel#:_____

Email:_____ Occupation:_____

Would you like to be added to my mailing list for a quarterly e-newsletter and periodic updates? Yes No
Have you ever 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:_____
Name and Address of Primary Care Physician:_____
How did you hear about RW Massage Therapy or your Therapist?_____

Medical Information ***It is important that you complete this portion as accurately as possible***

Cardiovascular
- ☐ High Blood Pressure
- ☐ Low Blood Pressure
- ☐ CCHF
- ☐ Heart Attack
- ☐ Phlebitis/varicose veins
- ☐ Stroke/CVA
- ☐ Pacemaker or similar device
- ☐ Heart Disease

Is there a family history of any of the above? Y N
What?_____

Respiratory
- ☐ Chronic Cough
- ☐ Shortness of Breath
- ☐ Bronchitis
- ☐ Asthma
- ☐ Emphysema

Is there a family history of any of the above? Y N
Which?_____

Infections
- ☐ Hepatitis
- ☐ Skin Conditions
- ☐ TB
- ☐ HIV
- ☐ Herpes

Other Conditions
- ☐ Loss of Sensation, Where? _____
- ☐ Diabetes, Onset:_____
- ☐ Allergies/Hypersensitivity

What?_____
Type of Reaction:_____
- ☐ Epilepsy
- ☐ Cancer, Where?_____
- ☐ Skin Conditions

What and Where?_____ _____
- ☐ Arthritis

Is there a family history of any of the above? Y N
Which?_____

Head/Neck
- ☐ History of headaches/migraines
- ☐ Vision Problems
- ☐ Vision Loss
- ☐ Ear Problems
- ☐ Hearing Loss

Reproduction
- ☐ Pregnant Due:_____
- ☐ Gynaecological Conditions

What?_____
- ☐ Breast Pain
- ☐ Other:_____

Soft Tissue/Joint Pain
- ☐ Neck
- ☐ Upper Back/Shoulders
- ☐ Arms/Hands
- ☐ Mid Back
- ☐ Low Back
- ☐ Hips/Buttocks
- ☐ Legs/Knees/Feet

Do you have any other medical conditions? (eg. digestive conditions, haemophilia, osteoporosis, mental illness)
_____

Do you have internal pins, wires, artificial joints, or special equipment? If so, where?
_____

Current Medications: Condition it treats:

_____ _____
_____ _____
_____ _____

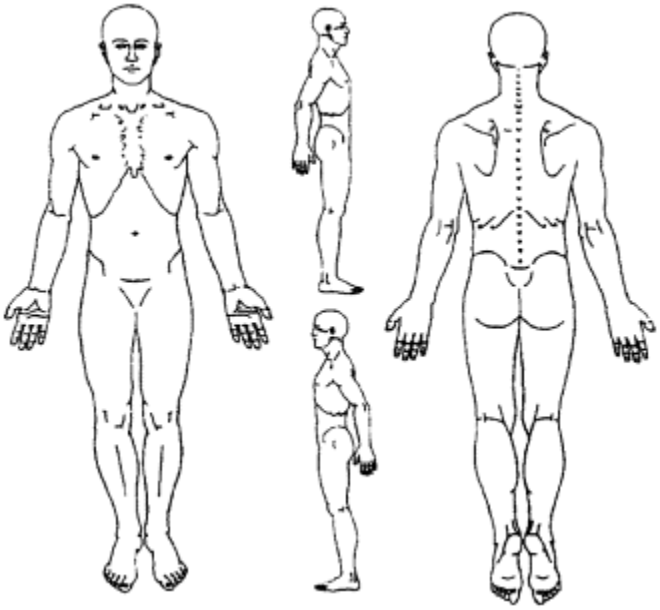
Previous injury/surgery: Date of injury/surgery:

_____ _____

_____ _____

_____ _____

Please Circle your areas of complaint on the diagram provided below:



Please mark on the line below the level of your discomfort.

_____

0 5 10

No Pain Moderate Worst Pain

Is this pain/discomfort the result of an injury or car accident? If yes, please provide details:_____

_____

Have you seen your physician (or other doctor) for this issue? Y N

Diagnosis?_____

Does this interfere with your work or daily activities? Y N

Are you currently receiving treatment from another health care professional? Y N What and who?_____

Is there anything else you would like your massage therapist to know?_____

What is your primary concern (reason for seeking Massage Therapy)?

_____

Overall, how is your general health?_____

Policy and Fee Schedule

Appointments: Massage Therapy sessions are booked by appointment only. Please provide 24 hours for any cancellations.

Payment: Payment is expected in full for each visit. Payments methods include cash, cheque, Interac (debit), Visa and MC.

Fees: 30 minutes - $60.00
45 minutes - $80.00
60 minutes - $100.00
90 minutes - $140.00

In compliance with the "Personal Health Information Protection Act", written consent is required before any information can be released to a third party (ie. Insurance company). There may be a fee to obtain a copy of your files upon written request.

I understand that Registered Massage Therapists do not diagnose illness, disease or any mental or physical disorder. I have stated all medical conditions that I am aware of and will update the Massage Therapist of any changes in my health status.

Signature:_____ Date:_____

Clinic Use Only: Updates Required Annually

Date of Initial Health History:_____

Date of update: Details: