Health History Dates
Initial: _____
Update 1:_____
Update 2:_____
Update 3:_____
Update 4:_____

Massage Therapist:

_____

Registered Massage Therapy: Confidential Health History Form

An accurate and current health history is important in ensuring the appropriateness and safety concerns in receiving a massage therapy treatment. If your health status changes in the future, please advise your massage therapist. All information gathered for this treatment is confidential except as required by law to facilitate assessment of your treatment. Only your written consent may allow the release of any information.

Surname: _____ First Name: _____

Address: _____ City: _____ Province: _____

Postal Code: _____ Date of Birth (MM/DD/YY): ____/____/____ Occupation: _____

Home Ph: _____ Work Ph: _____ Cell Ph: _____

Email: _____ Have you had registered massage before? Y N

Reason for consulting with a massage therapist:

Relaxation Prevention/Maintenance
Stress Relief Problem Correction Referred by: _____

Specific area(s) of concern: (Please indicate Right or Left):

Hand R or L	Feet R or L	Chest	Head
Arms R or L	Knees R or L	Abdomen	Neck R or L
Shoulders R or L	Legs R or L	Hip R or L	Back Upper / Mid / Low

Symptom description(s):

Dull ache	Tingling	Cramping	Twitching
Sharpness	Stiffness	Swelling	Radiating
Fiery	Stabbing	Numbness	Weakness

Occurrence of symptoms:

Cause: _____

When the symptoms began: _____

How often: Constant Periodic Chronic Acute

Frequency: _____ Duration: _____ Intensity: _____

Aggravating factor(s): _____

Relieving factor(s): _____

Physician's name: _____ Address: _____

Phone: _____ Date of last medical exam: (DD/MM/YY): ____/____/____

Current medication(s) (including vitamins and natural supplements and for what condition(s)):

_____

This form is double sided >

Operations, injuries and illness and when: (within the past 2 years):

_____

Present involvement in other health care (reason and how often):

Chiropractor: _____

Physiotherapy: _____

Massage Therapy: _____

Other: _____

With prior notice, permission to consult with listed professional if necessary *Yes* *No*

Please indicate conditions that you have (or mark "F" if in your family history):

Heart (heart disease)	Chronic cough	Cysts / Warts / Bruises
Chronic heart failure	Spasms / Sprains / Strains	Tendonitis / Bursitis
Myocardial infarction (Heart attack)	Headaches: current __ history of__	Rashes / Open sores
Cardiovascular accident (Stroke)	Migraines: history of___	Epilepsy
Circulation problems	Fainting / Dizziness	Pregnancy _____ mo.
High blood pressure	Fibromyalgia	Nausea
Low blood pressure	Arthritis	Constipation
Varicose veins / Phlebitis	Osteoporosis	Diarrhea
Asthma / Bronchitis / Emphysema	Multiple sclerosis	Insomnia
Difficulty breathing	Diabetes	Prone to bruises
Cancer	Vision/Hearing conditions	

Contagious disease (for example: herpes, H.I.V., T.B., hepatitis): _____

Allergies: _____

Other conditions (for example: gynecological, internal pains, wires, artificial joints, implants):

_____

Lifestyle questions:

Water (cups) ____ per day Caffeine (cups) ____ per day Regular activity* ____ per week

*Type: _____

Fee and Cancellation Policy

All payments will be due upon services rendered. Registered massages are not a benefit of OHIP. However, many private health insurance policies include massage therapy coverage (for example: PSHP, formerly known as GSMIP). A full 24 hour notice is required for the cancellation of your appointment, otherwise you will be charged the full fee of the massage. I understand the policies listed.

Signature: _____ Date: _____

Additional Notes- Massage Therapist use: