Health History Form – Page 1

The information requested 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 confidential unless allowed or required by law. Your written permission will be required to release any information. Please see our Privacy Policy, which is attached to the clipboard. Let us know if there are any changes in your health status.

Name_____ Date of Birth _____

Address_____ Town_____ Postal Code_____

Phone Number_____ Alternate _____Occupation _____

Family Doctor_____ Address _____ Phone # _____

Today's Date_____ Email _____

Have you received massage therapy before? Yes [ ] No [ ] Other bodywork? No [ ] Yes [ ] _____
How did you hear about us? Internet [ ] Yellow Pages [ ] Promo Material [ ] Live in Neighbourhood [ ] Other _____
Were you referred by a friend? [ ] Their name: _____
Were you referred by a health care practitioner? [ ] Their name & address: _____

Cardiovascular
[ ] High Blood Pressure
[ ] Low Blood Pressure
[ ] Chronic Congestive Heart Failure
[ ] Heart Attack: date _____
[ ] Heart Disease _____
[ ] Phlebitis / Varicose Veins
[ ] Stroke / Cerebral Vascular Accident
date:_____
[ ] Pacemaker or similar device
Is there a family history of any of the above?
[ ] Yes [ ] No
[ ]other _____

Respiratory
[ ] Chronic cough
[ ] Shortness of breath
[ ] Bronchitis
[ ] Asthma
[ ] Emphysema
[ ] Lung Disease_____

Is there a family history of any of the above?
[ ] Yes [ ] No

Infections
[ ] Hepatitis: type? _____
[ ] Skin Conditions: [ ] Eczema
[ ] Psoriasis [ ] Other_____
[ ] Tuberculosis
[ ] HIV
[ ] Herpes/Cold sores

Head/Neck
[ ] History of headaches
[ ] History of migraines
[ ] Vision loss
[ ] Vision problems_____
[ ] Hearing loss
[ ] Ear problems_____
[ ] Balance problems/vertigo/dizziness
[ ] Whiplash: date_____

Neuromuscular/Autoimmune
[ ] Fibromyalgia [ ] Celiac/IBS
[ ] Chronic Fatigue Syndrome
[ ] Multiple Sclerosis
[ ] Diabetes Type? _____
Onset:_____

Other Conditions
[ ] Loss of sensation -
where?_____
onset:_____
[ ] Allergies/Hypersensitivity to
what?_____
type of reaction:_____

[ ] Arthritis
What type?_____
joints affected:_____
Is there a family history of arthritis?
[ ] Yes [ ] No

[ ] Epilepsy
[ ] Cancer _____
Date of diagnosis :_____
Are you currently undergoing treatment?
[ ] Yes [ ] No

Women
[ ] Pregnancy: due date_____
Please see reverse for consent form
[ ] Other gynecological conditions
_____
_____

Current Medications _____
_____

Conditions treated _____
_____

Are you currently receiving treatment from another health care practitioner? Yes [ ] No [ ]
If yes, for what? _____

Surgery: date _____nature:_____
_____

Do you have any pins, wires, artificial joints or special equipment? Yes [ ] No [ ]
What? _____

Where? _____

Do you have any other medical conditions?(i.e. osteoporosis, mental health, digestive disorders etc.)_____
_____

Injury: date _____nature: _____
_____

Health History Form – Page 2

What is the reason you are seeking massage therapy? _____

What aggravates your condition? _____Relieves it? _____

What physical activities do you engage in? _____ Overall, how is your general health? _____

Check areas of any joint or tissue discomfort:

Head/Scalp [ ] Face [ ] Jaw [ ] Neck [ ] Shoulder [ ] Upper Back [ ] Mid Back [ ] Lower Back [ ] Tailbone [ ] Gluteus [ ]

Thigh front [ ] Thigh back [ ] Calf front [ ] Calf back [ ] Feet [ ] Hands [ ] Arms [ ] Chest [ ] Abdomen [ ] Groin [ ]

Intake for Pregnant Clients

Due Date _____This will be my_____ (1st, 2nd, etc.) pregnancy. This will be my _____ (1st, 2nd etc.) birth

Please check any conditions you are currently experiencing or circle if you have experienced in the past:

! Hypertension [ ] Diabetes [ ] ! Edema/Swelling [ ] Leg Cramps [ ] Nausea [ ] Visual Disturbances [ ] Bladder infection [ ]
Separation of the Rectus Abdominal muscles [ ] Separation of the Symphysis Pubis [ ] Varicose veins [ ] Multiple birth [ ] Fatigue [ ]
History of miscarriage [ ] !! Abdominal cramping [ ] !! Phlebitis or blood clot [ ] Problems with placenta [ ] !! Pre-eclampsia [ ]

If you are currently experiencing any of the conditions marked !, or have experienced any of the conditions marked !! in the past, please consult your prenatal health care practitioner before continuing massage.
If you are currently experiencing any of the conditions marked !!, massage therapy is not advised without express consent from your prenatal health care practitioner.

List any other conditions or problems in current or past pregnancies
_____

Consent to Release Information to Insurance Company

I hereby give my consent to the Registered Massage Therapist to exchange medical information and/or other information necessary with other medical professionals handling my case, WSIB (if applicable) and/or motor vehicle insurance company (if applicable) and any third party payers and benefit plan insurance companies

I understand that this information will be used to provide me with the most individualized and optimized massage therapy treatment.

Cancellation Policy – Due to the high client volume in the clinic, for any no show or cancelled appointment the day of your massage there will be a fee for the amount of the scheduled appointment. Late arrivals will receive the remaining time left with full payment.

Consent for Treatment

I hereby offer my consent to participating in massage therapy treatment which may include pain control modalities, exercise prescription, manual therapy passive muscle stretching and healthcare education/teaching. I understand that I may withdraw my consent at any time without penalty. There is a zero-tolerance sexual harassment policy. Registered Massage Therapy is intended to be therapeutic. It is not meant to be a sexual experience. Any inappropriate behavior or remarks will result in immediate termination of the treatment.

[ ] I HAVE READ AND ACKNOWLEDGE THE PRIVACY POLICY AND CONSENT FORMS OF THIS MASSAGE THERAPY PRACTICE

Signed consent (signature) _____ Date _____

I understand that by signing this form that I am choosing to proceed with the treatment and/or treatment plan proposed at the time. I understand that I may change my mind, altar, or refuse treatment at any time during this or any other treatment. This completed form will be kept in my client file by Annette Kelsey RMT

Please read and sign – (only if applicable)

I have been informed of and have understood the reason(s) for receiving massage to my:

[ ] _____buttocks [ ] _____ inner thigh(s) [ ] _____chest wall muscles [ ] _____ breast tissue

Regarding massage of the breast(s) I have been informed of the clinical indicators for breast massage that relate to my situation:
_____(initial) (Massage Therapy Standards of Practice)
As well, I understand that the nipples and/or areolas of my breasts will not be touched during the breast massage

I understand that I can alter or rescind my consent at any time during this or any future treatment. I am voluntarily giving my consent for the treatment and/or treatment plan discussed with me

Signed consent (signature) _____ Date: _____