HEALTH HISTORY FORM

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 confidentially unless allowed or required by law. Your written permission will be required to release any information.

Name:	**Phone # res:**
Address:	**Occupation:**
Postal Code:	**Date of Birth:**
Email:	**How did you hear about clinic/therapist?**

Have you received a massage 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 the above? Yes No

Respiratory
- ☐ Chronic cough
- ☐ Shortness of Breath
- ☐ Bronchitis
- ☐ Emphysema

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

Infections
- ☐ Hepatitis
- ☐ Skin conditions
- ☐ Tuberculosis
- ☐ HIV
- ☐ Herpes

Other conditions

Loss of sensation? Where? _____

☐ Diabetes: onset: _____

☐ Allergies/hypersensitivities?
what?: _____
Type of reaction: _____

☐ Epilepsy

Cancer, where? _____

Skin conditions: What? _____

Arthritis? What kind? _____

Is there a family history of arthritis?
Yes No

Head/Neck
- ☐ History of headaches
- ☐ History of migraines
- ☐ Vision problems
- ☐ Hearing loss

Women
- ☐ Pregnant? Due: _____
- ☐ Gynecological conditions, what? _____

Overall how is your general health? _____

Primary Care Physician: _____

Address: _____

History of motor vehicle accident?
Yes No, When: _____

Current Medications: _____

Condition it treats: _____

Supplements: _____

Are you currently receiving treatment from another health care professional? ☐ Yes ☐ No, if yes, for what?

_____

Surgery- Date: _____

Nature:

Do you have any other medical conditions? (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 are seeking massage therapy?

_____

CURRENT HEALTH CONDITON(S)

CURRENT COMPLAINT(S) _____

_____

HOW DID THIS CONDITION BEGIN_____

DATE OF ONSET_____ HAS IT OCCURED BEFORE ☐ YES ☐ NO

WHAT AGGRAVATES YOUR CONDITION ☐ SITTING ☐ STANDING ☐ BENDING ☐ LIFTING ☐ WALKING

☐ LYING ☐ COLD ☐ DAMPNESS ☐ OTHER _____

WHAT RELIEVES YOUR CONDITION ☐ BEDREST ☐ ICE ☐ HEAT ☐ MASSAGE ☐ MEDICATION ☐ OTHER

_____

IS THE PAIN ☐ CONSTANT ☐ INTERMITTENT ☐ WORSENING ☐ IMPROVING

TYPE OF PAIN ☐ SHARP ☐ DULL ☐ ACHE ☐ PINS & NEEDLES ☐ NUMB ☐ BURNING ☐ SHOOTING

☐ OTHER _____

TO WHAT DEGREE DOES THE PAIN HAMPER YOUR ABILITY TO (1 Not at all, 10 Completely)

WORK	1 _____	10
ENJOY FAMILY/SOCIAL LIFE	1 _____	10
ENJOY HOBBIES/SPORTS	1 _____	10

OTHER DOCTORS SEEN FOR THIS CONDITION ☐ YES ☐ NO WHO _____

TYPE OF TREATMENT _____ RESULTS _____

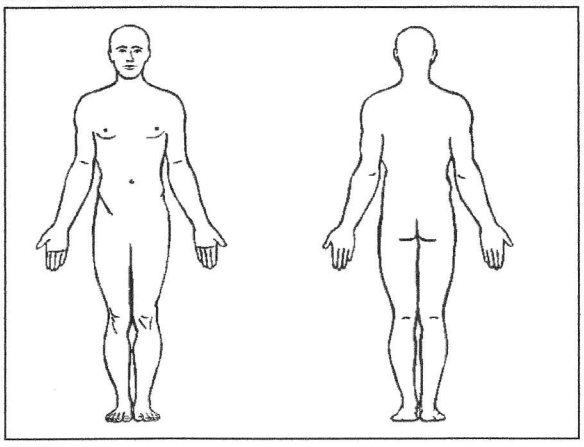
DRUGS YOU NOW TAKE ☐ NERVE PILLS ☐ PAIN KILLERS ☐ MUSCLE RELAXERS ☐ BLOOD PRESSURE

☐ INSULIN ☐ OTHER _____

DO YOU SUFFER FROM ANY OTHER CONDITION OTHER THAN THAT FOR WHICH YOU ARE NOW CONSULTING US? _____

PLEASE COMPLETE THE FOLLOWING DIAGRAMS

1. CIRCLE AREAS OF PAIN
2. USE THE FOLLOWING SYMBOLS
   - Pins & Needles 0000
   - Numbness xxxx
   - Burning ////
   - Aching ssss
   - Stabbing ....



INFORMED CONSENT
OFFICE AND MASSAGE THERAPY PROCEDURES

PLEASE READ CAREFULLY:

Consent for Massage Therapy

In Accordance with the Standards of Practice and the Code of Ethics of the College of Massage Therapists of Ontario:

☐ I have the opportunity to discuss the nature and purpose of the proposed assessment/reassessment/treatment/treatment plan with the Massage Therapist.

☐ I am aware that I may discontinue the assessment/reassessment/treatment/treatment plan at any time at my discretion.

☐ I understand that there are possible side effects/risks to the treatment including, but not limited to: light-headedness, muscle aches and pains, bruising, swelling, redness and/or other skin reactions.

☐ I understand the fee structure and accept full responsibility for prompt payment. I understand and agree that if I am late for my appointment, I will receive the remainder of the appointment time but will be responsible for the full payment of the scheduled appointment. **Cancellation policy**: I also acknowledge the policy that appointments cancelled with less than 24 hour notice or missed will be subject to a $50.00 charge.

Specific areas of the body that may be treated include

Upper back Mid back Lower back Head Neck and shoulders Arms
Wrists and hands Legs and feet Inner Thighs Buttocks (gluteal muscles)
Chest wall musculature

When the treatments of sensitive areas such as gluteal, inner thigh, or chest wall are indicated during the course of treatment, it is especially important that you, the client, fully understand the nature and purpose of this treatment. If you have any questions at any time, please do not hesitate to ask. A record of this consent will be kept in your confidential client file.

I have read the above information and have had the opportunity to ask questions that I have about the content. By signing below I give my consent to the Massage Therapist to proceed with assessment/reassessment/treatment as presented to me. I intend this consent to cover the entire course of treatment for my present condition and for any ongoing issues that I may present with. I understand that I may alter or withdraw my consent at any time.

Patient's Name_____
Signature of Patient (parent or guardian)
_____
Date Signed_____
Witness: _____ Date: _____