Health History Form

The information request 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 # _____

Address: _____

Occupation: _____ Date of Birth: _____

Have you 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. _____

_____

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 any of the above? Yes No

Respiratory

- chronic cough
- shortness of breath
- bronchitis
- asthma
- emphysema

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

Infections

- hepatitis
- skin conditions
- TB
- HIV
- herpes

Other Conditions

- loss of sensation, where? _____
- diabetes, onset: _____
- allergies/hypersensitivity to what? _____
- type of reaction: _____
- epilepsy
- cancer, where? _____
- skin conditions, what? _____
- arthritis

is there a family history of arthritis? Yes No

Head/Neck

- history of headaches
- history of migraines
- vision problems
- vision loss
- ear problems
- hearing loss

Women

- pregnant, due: _____
- gynaecological conditions, what? _____

Overall, how is your general health? _____

Primary Care Physician: _____

Address: _____

_____

Current Medications: _____

condition it treats: _____

_____

Are you currently receiving treatment from another health care professional? Yes No

If yes, for what? _____

_____

Surgery – date _____

nature: _____

Injury – date _____

nature: _____

Do you have any other medical conditions? (e.g. 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 you are seeking massage therapy? Please include the location of any tissue or joint discomfort.

_____

_____

_____

Notes:

Date of initial Health History: _____

Update 1 _____

Update 2 _____

Update 3 _____

Update 4 _____

INFORMED CONSENT TO MASSAGE THERAPY TREATMENT

I understand there is a 24 hour cancellation policy and that I am responsible to pay the fee in the amount of $25 in the event that adequate cancellation notice was not provided.

I understand that the massage therapist is providing massage therapy services within their scope of practice as defined by the College of Massage Therapists of Ontario.

I hereby consent for my therapist to treat me with massage therapy for the above noted purposes including such assessments, examinations and techniques, which may be recommended, by my therapist.

I acknowledge that the therapist is not a physician and does not diagnose illness or disease or any other physical or mental disorder. I clearly understand that massage therapy is not a substitute for a medical examination. It is recommended that I attend my personal physician for any ailments that I may be experiencing. I acknowledge that no assurance or guarantee has been provided to me as to the results of the treatment. I acknowledge that with any treatment there can be risks and those risks have been explained to me and I assume those risks.

I acknowledge and understand that the therapist must be fully aware of my existing medical conditions. I have completed my medical history form as provided by my therapist and disclosed to the therapist all of those medical conditions affecting me. It is my responsibility to keep the massage therapist updated on my medical history. The information I have provided is true and complete to the best of my knowledge.

I authorize my therapist to release or obtain information pertaining to my condition(s) and/or treatment to/from my other caregivers or third party payers.

I have read the above noted consent and I have had the opportunity to question the contents and my therapy. By signing this form, I confirm my consent to treatment and intend this consent to cover the treatment discussed with me and such additional treatment as proposed by my therapist from time to time, to deal with my physical condition and for which I have sought treatment. I understand that at any time I may withdraw my consent and treatment will be stopped.

Patient Name _____ Signature of Patient/Guardian _____

Date Signed _____