

Health History Form

An accurate health history is important to ensure that a treatment is safe for you. If your health status changes in the future please let your Registered Massage Therapist (RMT) know. You will be asked to provide written authorization for release of any information. Please fill out this form as detailed as possible. Thank You.

Name: _____ Date of Birth: _____

Address: _____ City: _____ Postal: _____

Phone#1: _____
 Home
 Cell
 Work

Occupation: _____

Phone#2: _____
 Home
 Cell
 Work

How did you hear about us: _____

Email (Only Used Internally For Notification Purposes): _____

Did a health care practitioner refer you for massage therapy treatment ? Yes No

Family doctors name and location: _____

Cardiovascular

- High Blood Pressure
- Low Blood Pressure
- Heart Attack
- Phlebitis
- Stroke/CVA
- Pacemaker or Similar
- Varicose Veins
- Other: _____

Respiratory

- Chronic Cough
- Shortness of Breath
- Bronchitis
- Asthma
- Emphysema
- Smoking
- Allergies: _____

Head/Neck

- Vision Problems
- Hearing Loss
- Migraines
- Headaches
- Dizziness
- Other: _____

Soft Tissue and Joint Dysfunction

- Neck
- Upper Back
- Low Back
- Mid Back
- Shoulders
- Arms R/L
- Legs R/L
- Other: _____

Other Conditions

- Loss of Sensation (Where): _____
- Diabetes (Type/Onset) _____
- Epilepsy (Type/Triggers) _____
- Cancer (Where/When) _____
- Arthritis (Type/Where) _____
- Other: _____

Infections

- Hepatitis
- TB
- HIV
- Plantar Warts
- Other: _____

Women

- Menstrual Problems
- Menopausal
- Pregnant: Due Date: _____

Skin

- Skin Conditions
- Bruise Easily
- Other: _____

Current Medications _____ What It Treats _____

Current Medications _____ What It Treats _____

Current Medications _____ What It Treats _____

Previous Surgeries and Dates _____

Of Special Note (Presence of Internal Pins, Wires, Special Equipment) _____

Other Health Care (Chiropractor, Physiotherapist, Naturopath, etc) _____

Have you received Massage Therapy before? Yes No

What is the reason you are seeking Massage Therapy? _____

PLEASE TURN OVER SHEET TO COMPLETE

Have you received any other treatment for this condition? _____

If you are experiencing pain or discomfort: (If not leave, please leave fields regarding pain blank)

Cause of pain if known _____ How long have you had this pain _____

Are there any daily activities that you are unable to do because of pain _____

Informed Consent

Massage Therapy involves the manipulation of the soft tissues and joints of the body. With each treatment the RMT will leave the room while the client disrobes to their level of comfort. The client will then lay on the table between the sheets until the RMT returns. Only areas of the body discussed before treatment will be addressed unless verbal consent is given during treatment. The linens are changed for each client. Please inform your RMT if any techniques or pressures become uncomfortable or painful. You have the right to stop the massage at any time during your appointment.

Please Note and Initial

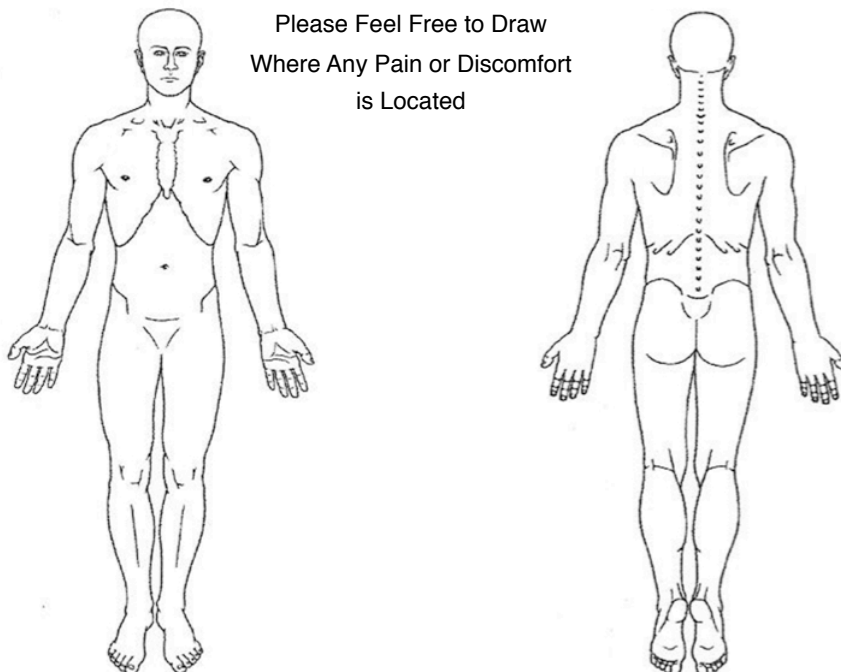
Missed Appointment and Late Cancellation Fee:

Any Missed Appointment or Late Cancellation made within 24 hours will be subject to a \$35.00 Fee including HST. Initial

Missed Appointments and Insurance Coverage: I understand that if I have insurance coverage that a receipt for massage cannot be provided for any missed appointment as it is considered a fraudulent act. I will be required to pay the Missed Appointment/Late Cancellation Fee mentioned above. Initial

Payment: Payments are required same day as treatment unless other arrangements have been made between you and the RMT you see that day. Initial

Please Sign and Date: _____ **Date:** _____



PLEASE TURN OVER SHEET TO COMPLETE

Healthy History Update
(Office Use)

- 1. _____
- 2. _____
- 3. _____
- 4. _____