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

REGISTERED MASSAGE THERAPY

I hereby consent to massage therapy by the Registered Massage Therapist identified below. I have been informed of the following:

*What the treatment is

*Which areas that will need to be worked on

* Benefits of treatment

* Risks of the treatment

*Alternatives types of treatment

* The right to terminate/modify/change the treatment at any time at my request

All of the information I provide is confidential, unless I give my permission, and written consent to release my information. My consent is voluntary, and I can withdraw my consent at any time either verbally or in writing.

If there is any change in my health or in my condition, I must inform, and update the Registered Massage Therapist, as it is my responsibility.

I am informed, and I understand that as in any medical treatment, there may be temporary side effects to massage, such as muscle soreness, or cramping, headaches, light headedness, fainting, nausea, or heart rhythm irregularities.

This consent form will cover the entire course of treatment for my present condition, starting on the date indicated below.

I also understand that my information will be shared with other Registered Massage Therapists that will work with me, and that the College of Massage Therapists of Ontario can assess my file at any time.

Furthermore, I understand, and I am fully aware that I need to give 48 hours' notice if I need to cancel or change my appointment, or else I will be charged a fee of $25 for not showing up.

Clients Signature: Date: