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:(D/M/Y)_____

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 TO COMPLETE DOCUMENTATION

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_____

I**nformed Consent**

Massage Therapy involves treating the muscles, 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. The linens are changed for each client. Please inform your RMT if any techniques or pressures become uncomfortable of painful. You have the right to stop the massage at any time during your appointment. Only areas of the body discussed before treatment will be treated unless verbal consent is given during treatment; with the exception of "sensitive areas" which will also require written consent. Sensitive areas include: glutes/buttocks, chest muscles, inner thigh and breasts. You will be given a chance before treatment starts to ask questions.

_____

Please Note and Initial

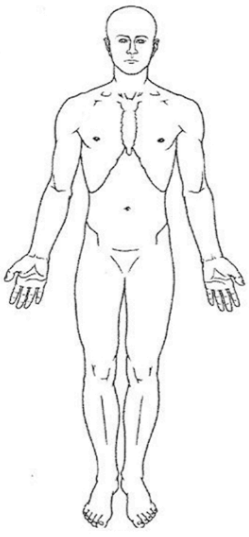
Missed Appointment and Late Cancellation Fee:
Any Missed Appointment or Late Cancellation made within 24 hours will be subject to a $50.00 Fee.
Initial ☐

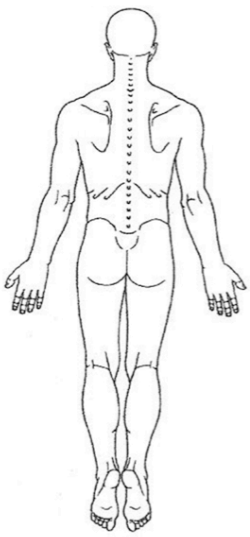
Missed Appointments and Insurance Coverage: I understand that if I have insurance coverage that a receipt for massage cannot be provided for any missed appointment as it is considered a fraudulent act. I will be required to pay the Missed Appointment/Late Cancellation Fee mentioned above. **Initial**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

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

Greenshield Clients: At this time I offer direct billing for Greenshield. All plans are different and some require prescriptions from your family doctor in order to bill. Some plans cover all or a portion of your plan. Please confirm with Greenshield the details and requirements of your plan. **Initial If Applicable** ☐

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





Healthy History Update
(Office Use)

1._____

2_____

3_____

4_____