Print Form

Health History & Consent 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:_____ Date of Birth:_____

Address: _____ Phone # (home):_____

_____ (work):_____

Doctor – Name: _____ Occupation: _____

Address:_____ Allergies:_____

Phone: _____ E-mail:_____

(If you wish to receive e-mail reminders)

Date of last visit:_____/_____/_____

(day) (month) (year)

Reason you are seeking massage therapy? _____

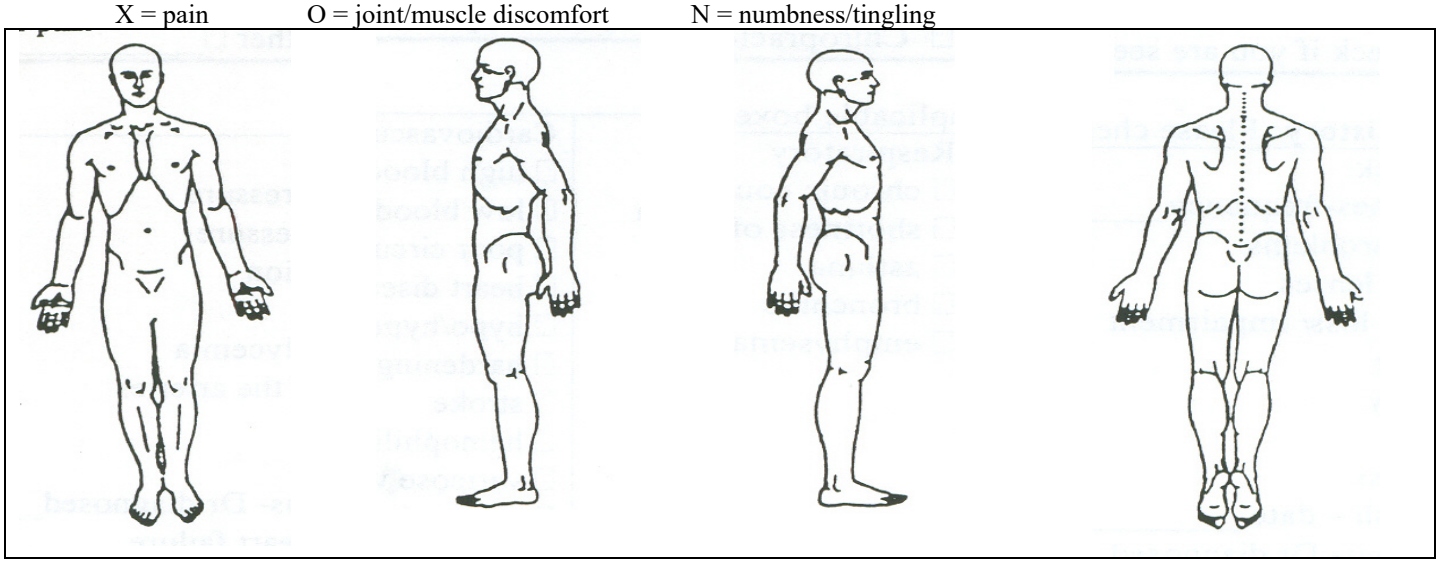
How long has condition existed?_____ In general, how is your health?_____

Referred to massage by: Doctor ☐ Chiropractor ☐ Physiotherapist ☐ Other ☐_____

Have you had massage in the past? YES ☐ NO ☐ Relaxation ☐ Therapeutic ☐

Please identify your **current** symptoms on the diagram below:

X = pain O = joint/muscle discomfort N = numbness/tingling



- Massage therapy is most effective when applied directly to the skin, but personal boundaries are determined by you, the client. You will be covered by a sheet at all times except for the area being treated.
- I, as the therapist, will work closely with you to develop an informed treatment plan where both play an active part in the therapeutic process.
- Deep massage may be associated with bruising and tenderness. If suggested by the RMT and consented to by the client, it is the client's responsibility to make the therapist aware of the situation and to discuss treatment alternatives.
- You, the client, are responsible for informing the therapist of any changes in your health status. It is also your responsibility to communicate with the therapist before, during and after the course of a treatment. You have the right to ask questions about procedure or effects of the treatment.
- ***At any time before or during the massage you can ask the therapist to alter or stop the course of treatment.***
- I, the client, have read and do understand the above. I have had the opportunity to ask questions of the registered massage therapist (RMT) and do consent to a therapeutic massage as outlined by the registered massage therapist.
- **I understand that I will be charged the full treatment fee for any appointment missed or cancelled with less than 24 hours notice.**

_____ _____

Signature Date

Print Form

Health History: Please check the conditions that are **current** or that you have **previously** experienced.

Head/Neck:

Current Previous

- ☐ ☐ headache - frequency_____
  - Tension ☐
  - Migraines ☐
  - Dr. diagnosed? ☐
  - Type _____
- ☐ ☐ vision problems
- ☐ ☐ contact lenses
- ☐ ☐ earaches/hearing loss
- ☐ ☐ sinus
- ☐ ☐ whiplash – date _____

Cardiovascular:

Current Previous

- ☐ ☐ high blood pressure
- ☐ ☐ low blood pressure
- ☐ ☐ poor circulation
- ☐ ☐ congestive heart failure
- ☐ ☐ varicose veins
  - Dr diagnosed? ☐
- ☐ ☐ cerebro-vascular accident_____
  - affected _____
- ☐ ☐ myocardial infarction
- ☐ ☐ heart disease
- ☐ ☐ phlebitis

Digestive/Uro-genital:

Current Previous

- ☐ ☐ difficult digestion
- ☐ ☐ constipation
- ☐ ☐ liver _____
  - gall bladder _____
- ☐ ☐ kidney _____
- ☐ ☐ bladder _____
- ☐ ☐ ulcers _____
- ☐ ☐ diabetes: type I ☐ type II ☐
- ☐ ☐ poor appetite

Skin:

Current Previous

- ☐ ☐ sensitive skin
- ☐ ☐ bruise easily
- ☐ ☐ skin condition
  - type _____

Respiratory:

Current Previous

- ☐ ☐ chronic cough
- ☐ ☐ shortness of breath
- ☐ ☐ breathing problems
  - type _____
- ☐ ☐ smoking

Infections:

Current Previous

- ☐ ☐ hepatitis
- ☐ ☐ plantar warts
- ☐ ☐ TB
- ☐ ☐ HIV, AIDS
- ☐ ☐ herpes
- ☐ ☐ other _____

Women ♀:

Current Previous

- ☐ ☐ menstrual problems
- ☐ ☐ menopausal problems
- ☐ ☐ c-section /other gynaecological surgery _____
- ☐ pregnant – due ____/____/____
  - # children _____

Other:

Current Previous

- ☐ ☑ fatigue
- ☐ ☐ insomnia
- ☐ ☐ cancer – type _____
- ☐ other diagnosed diseases/conditions _____
  - loss of sensation? where? _____
- ☐ osteoporosis
- ☐ epilepsy
- ☐ arthritis – RA ☐ OA ☐
  - Dr diagnosed? ☐
  - areas affected: _____
  - family history of arthritis? Yes No

Current Medications:

Name _____ Condition _____

_____ _____

_____ _____

Other medical conditions to note:

(ie. pins, wires, plates, artificial joints, canes..)

_____ location _____

_____ location _____

Injury:

type date

_____ _____

_____ _____

_____ _____

Surgeries:

type date

_____ _____

_____ _____

_____ _____

Are you currently receiving treatment from another health care professional? _____

for office use

Initial Health History taken: ____/____/____

Update 1: ____/____/____

Update 2: ____/____/____

Update 3: ____/____/____

Update 4: ____/____/____