HEALTH HISTORY FORM

The information requested below will assist us in treating you safely. If your health status changes, please notify your RMT. Feel free to ask any questions about the information being requested. Please note that all information provided below will be kept confidential unless allowed or required by law. Your written permission will be required to release any information.

Name: _____
Address: _____
City: _____ Postal Code: _____
Date of Birth: (d) _____ (m) _____ (y) _____
Gender: ☐ Female ☐ Male
Occupation: _____

Family Physician: _____
Address: _____
Phone: (____)_____
Permission to consult Family Physician: ☐ YES ☐ NO

Date: _____
Phone (h): (____)_____
Phone (w): (____)_____
Cell #: (____)_____
E-mail: _____
Would you like to receive from our office - mail ☐ YES ☐ NO
- e-mail ☐ YES ☐ NO
(including appointment reminders, clinic updates and events, newsletters)
Did a health care practitioner refer you for massage therapy?
☐ YES ☐ NO
If yes, please provide their name and address:
_____

What is the reason you are seeking massage therapy? _____

Please indicate which 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 type: _____
- ☐ skin conditions _____
- ☐ tuberculosis (TB)
- ☐ HIV/AIDS
- ☐ 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 any of the above? ☐ YES ☐ NO
Is there a family history of arthritis?
☐ YES ☐ NO

WOMEN

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

GASTROINTESTINAL

- ☐ constipation
- ☐ diarrhea
- ☐ heartburn
- ☐ other: _____

SOFT TISSUE/JOINT PAIN

- ☐ neck
- ☐ upperback/shoulders
- ☐ arms/hands
- ☐ midback
- ☐ low back
- ☐ hips/legs
- ☐ knees/feet
- ☐ other: _____

HEAD/NECK

- ☐ headaches/migraines frequency:_____
- ☐ vision problems
- ☐ vision loss
- ☐ ear problems
- ☐ hearing loss

Overall, how is your general health?
☐ poor ☐ average ☐ good ☐ excellent

Are you currently receiving treatment from another health care practitioner?
☐ YES ☐ NO
If yes, for what? _____

Current medications: _____
Conditions it treats: _____

Other medical conditions? (ie. osteoporosis, mental illness) ☐ YES ☐ NO
What? _____

Any internal pins, wires, artificial joints, or special equipment? ☐ YES ☐ NO
What? _____ Where? _____

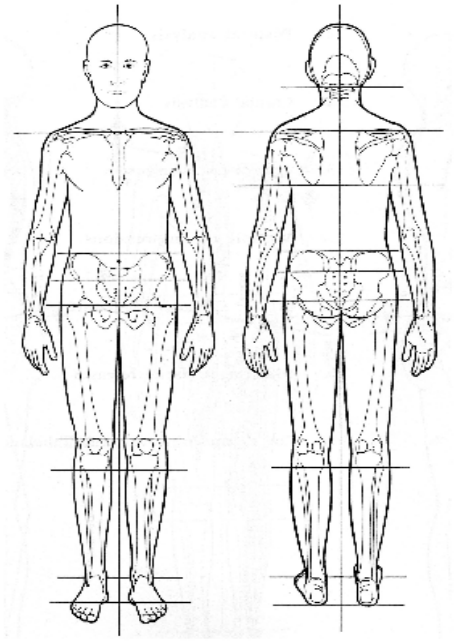
Surgery & Date: _____ Nature: _____
Injury & Date: _____ Nature: _____

Pls. complete reverse side

How did you hear about our clinic? ☐ phonebook ☐ web ☐ friend/family ☐ physician Name: _____
Which hand do you write with? ☐ right ☐ left ☐ both Which is your dominant side? ☐ right ☐ left
Do you sleep on your? ☐ back ☐ side (right/left) ☐ stomach Do you sleep well? ☐ YES ☐ NO
What kind of exercise/activities are you involved in? _____
Frequency: _____
Have you received massage therapy before? ☐ YES ☐ NO If yes, when was the last time? _____
What kind of pressure do you like? ☐ light ☐ moderate/medium ☐ deep ☐ very deep ☐ not sure

PAIN/DISCOMFORT DIAGRAM

Please indicate painful areas on diagram (using symbols):



SYMBOLS:

Numbness	• • • • •
Pins & Needles	o o o o o
Burning	x x x x x
Aching	★★★★
Stabbing	/ / / / / /

Please describe the pain:
☐ dull ☐ sharp ☐ constant ☐ radiating
☐ other: _____

Does the discomfort interfere with your work/daily activities?
☐ YES ☐ NO

Have you seen your doctor for this discomfort/problem?
☐ YES ☐ NO

Is this the result of an injury? ☐ YES ☐ NO
Date: _____ Injury type: _____

Have you ever been in a car accident? ☐ YES ☐ NO
If yes, when: _____ Details: _____

CONSENT

I understand that Registered Massage Therapists do not diagnose illness, disease or any mental or physical disorder; nor do they prescribe medical treatment, pharmaceuticals or perform spinal thrust manipulations. I have stated all medical conditions that I am aware of and will update the Massage Therapist of any changes in my health status.

I acknowledge I have discussed, or have had the opportunity to discuss with my RMT the nature and purpose of my treatment(s). I consent to the registered massage therapy treatments offered or recommended to me by my RMT. I intend this consent to apply to all my present and future care.

In compliance with the 'Personal Health Information Protection Act', written consent is required before any information can be released to a third party (ie. Insurance company).

I understand that I will be charged half the original appointment fee for any missed appointments, and am required to notify the clinic at least 48 hours in advance of my cancellation.

Signature: _____ Date: _____

Name (PRINT): _____

CLINIC USE ONLY
(updating required annually)

Date of initial Health History: _____
Update 1: _____ Details of update: _____
Update 2: _____ Details of update: _____
Update 3: _____ Details of update: _____

Registered Massage Therapist: _____, RMT