HEALTH HISTORY

Name:_____ Phone:_____ DOB:_____

Address:_____ Occupation:_____

Have you had massage therapy before? ☐ Yes ☐ No

Reason for visit:_____

What aggravates your condition?_____

What relieves your condition?_____

Is it getting: ☐ Worse ☐ Constant ☐ Comes/Goes ☐ Better

Type of Pain: ☐sharp ☐shooting ☐dull ☐boring ☐aching ☐referring ☐stabbing ☐throbbing

Are you seeing another healthcare professional? ☐ Yes ☐ No How is your health?_____

Surgeries/Injuries:_____

_____

Current medications and what they treat:_____

_____

Please indicate conditions that you are experiencing/ have experienced:

Cardiovascular

☐high/low blood pressure

☐heart attack

☐stroke

☐phlebitis/stroke

☐heart disease

☐chronic congestive heart failure

☐chest pain

Respiratory

☐cough

☐cold/flu/fever

☐bronchitis

☐emphysema

☐ asthma

☐shortness of breath

☐pneumonia

Head

☐migraines

☐headaches

☐vision problems/loss

☐hearing problems/loss

Gastrointestinal

☐IBS/crohns

☐gas/bloating

☐nausea/vomiting

☐constipation/diarrhea

☐heart burn/indigestion

☐abdominal cramping

☐colitis

Nervous system

☐numbness/ tingling

☐paralysis

☐dizziness/fainting

☐depression/mental illness

☐always feel cold/warm

Other

☐cancer

☐arthritis

☐diabetes

☐epilepsy

☐fibromyalgia/chronic fatigue

☐anemia/hemophilia

☐skin conditions

☐HIV

☐joint pain/stiffness

☐osteoporosis

☐clicking jaw

☐bladder trouble

☐allergies:_____

Women

☐menstrual problems

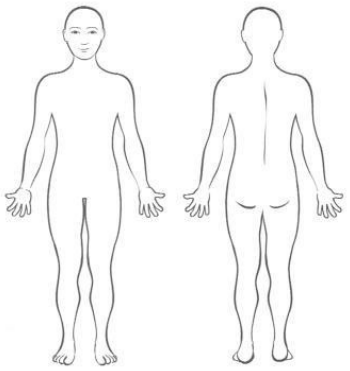
☐breast pain/lumps

Are you pregnant?

☐Yes ☐ No

Due Date:_____

Please outline the area of pain



HEALTH HISTORY

Informed Consent

- I understand that the massage therapist is providing massage therapy services within their scope of practice as defined by the College of Massage Therapists of Ontario
- I have completed my health history form and disclosed all medical conditions affecting me truthfully to the best of my ability.
- It is my responsibility to keep the massage therapist updated on my health history as it changes
- I consent for my therapist to treat me with massage therapy for the treatment plan discussed including assessments, examinations and techniques
- I acknowledge that the therapist does not diagnose illness or disease
- I acknowledge that no assurance or guarantee has been provided to me as to the results of the treatment.
- I acknowledge that with any treatment there can be risks and those risks have been explained to me and I assume those risks.
- My files are confidential and will be locked in a cabinet to which only my therapist has a key to; only myself and the therapist have access, unless I give written consent
- No inappropriate language or behaviour will be tolerated during the appointment
- I will be charged full fees for any missed or cancelled appointments that are not given 24 hours
- I understand that fees are subject to change without notice

I have read the above noted consent and I have had the opportunity to question the contents and my therapy. By signing this form, I confirm my consent to treatment and intend this consent to cover the treatment discussed with me and such additional treatments agreed upon by myself and my therapist. I understand that at any time I may withdraw my consent and treatment will be stopped.

Name:_____ Date:_____