Health History Form

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

Name: _____ Phone Number: _____

Address: _____ City: _____ Postal Code: _____

Date of Birth: _____ Occupation: _____

Have you received massage therapy before? Yes☐ No☐ Who referred you to the clinic? _____

Primary Care Physician: _____ Address: _____

Overall, how is your general health? _____

What is the reason you are seeking massage therapy? Please include the location and nature of any tissue or joint discomfort:

_____

Are there any areas you prefer not to be treated? _____

Please check all that you have previously (**P**) experienced or are currently (**C**) experiencing:

P	Cardiovascular	C
☐	High Blood Pressure	☐
☐	Low Blood Pressure	☐
☐	Chronic Congestive Heart Failure	☐
☐	Heart Attack	☐
☐	Phlebitis/Varicose Veins	☐
☐	Stroke/CVA	☐
☐	Pacemaker or similar device	☐
☐	Heart Disease	☐

Family history of any of the above? Yes☐ No☐

P	Respiratory	C
☐	Chronic Cough	☐
☐	Shortness of Breath	☐
☐	Bronchitis	☐
☐	Asthma	☐
☐	Emphysema	☐

Family history of any of the above? Yes☐ No☐

P	Head/Neck	C
☐	Headaches	☐
☐	Migraines	☐
☐	Vision Problems	☐
☐	Vision Loss	☐
☐	Ear Problems	☐
☐	Hearing Loss	☐

P	Infections	C
☐	TB	☐
☐	Hepatitis	☐
☐	HIV/AIDS	☐
☐	Infectious Skin Conditions	☐

P	Other Conditions	C
☐	Epilepsy	☐
☐	Osteoporosis	☐
☐	Disc Herniation	☐
☐	Degenerative Disc Disease	☐

Women

Pregnant, due: _____

_____

Gynecological conditions, what? _____

_____

Allergies/hypersensitivity to what? _____ Type of Allergic Reaction: _____

Diabetes, type/onset: _____ Loss of sensation, where? _____

Cancer, where? _____ Skin conditions, what? _____

Arthritis, what type/where? _____ Family history of arthritis? Yes☐ No☐

Do you have any other medical conditions? (e.g. digestive conditions, hemophilia, mental illness) Yes☐ No☐
What? _____

Are you currently receiving treatment from another health care professional? Yes☐ No☐
If yes, for what? _____

Current medications and the conditions they treat: _____

_____

Surgery- date/nature: _____ Injury- date/nature: _____

Do you have any internal pins, wires, artificial joints, or special equipment? Yes☐ No☐
If yes, what and where?
_____

Date of initial health history: _____
Update 1: _____ Update 4: _____
Update 2: _____ Update 5: _____
Update 3: _____ Update 6: _____

Policies and Consent for Massage Therapy

1. Massage therapy is a regulated health profession under the RHPA, and as such is bound by the rules and regulations of this act.

2. All fees for treatment are payable when the service is rendered. Payments can be made by cash, personal cheque, debit, Visa, or MasterCard. We do not provide direct billing for extended health insurance, therefore it is your responsibility to pay the fees directly to the provider and seek reimbursement for your claim using the provided receipt. The fee schedule is as follows:
   30min massage $60
   45min massage $75
   60min massage $90
   75min massage $105
   90min massage $120

3. You must provide a minimum of 24 hours' notice to cancel or change an appointment. Failure to adhere to this policy will result in a charge equal to the full appointment fee being applied to your account.

4. It is important to arrive on time for your scheduled appointment. No time extensions will be granted and a late arrival of more than 15 minutes will result in rescheduling of the appointment.

5. Common benefits of massage therapy include increased circulation, increased lymphatic drainage, and decreased muscle tone. Your massage therapist will develop a treatment plan specific to your needs and go over any additional benefits you may experience. If you do not receive treatment, you may not experience these benefits.

6. Risks of treatment can include bruising and temporarily increased pain. As such, please inform your massage therapist if they are using too much pressure. Any other risks will be identified after going over your health history form.

7. Side effects of treatment can include dizziness/light-headedness when getting off the table and redness of the skin if fascial work or deep pressure is used.

8. Alternatives for treatment can include the use of different massage techniques, hydrotherapy, a self-care program, and referral to another health care practitioner as your condition warrants and/or if it is in your best interest.

9. You have the right to stop or modify your treatment at any time. As such, please alert your massage therapist right away if you are uncomfortable in any way.

10. Please feel free to ask any questions before, during, and after your massage.

I have read, understood, and acknowledge all statements in the above policies and give my consent to receive treatment.

_____
Printed Name

_____ _____
Signature Date Signed