

Massage Therapy Health History

Please fill out this health history form as completely as possible. The information gathered through your health history provides your massage therapist with necessary information to treat you safely. Please feel free to ask any questions about why we are requesting this information. The information you provide will be kept confidential unless you submit a written request for us to release your information or if required by law.

Date: _____

Why Are You Here Today: _____

Please answer the following questions.

Name:	
Phone:	
Email:	
Address: _	
Date of Birth:	
Occupation:	
Emergency Contact:	
Phone:	
Were You Referred?	<input type="checkbox"/> Y <input type="checkbox"/> N
Who Referred You?	
Doctors Name:	
Doctor's Phone:	
Are You In Pain?	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> Dull <input type="checkbox"/> Sharp <input type="checkbox"/> Shooting <input type="checkbox"/> Achy <input type="checkbox"/> Numb <input type="checkbox"/> Tingling <input type="checkbox"/> Stiff_
Pain Scale (low) <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5 <input type="checkbox"/> 6 <input type="checkbox"/> 7 <input type="checkbox"/> 8 <input type="checkbox"/> 9 <input type="checkbox"/> 10 (high)	
Does The pain Radiate?	
What Aggravates Symptoms?	
What Relieves Symptoms?	
When Did This Start?	
Does Condition Interfere With	<input type="checkbox"/> Work <input type="checkbox"/> Sleep <input type="checkbox"/> Daily <input type="checkbox"/> Routine <input type="checkbox"/> Activities <input type="checkbox"/> Other
Have You Been Treated By	<input type="checkbox"/> Physician <input checked="" type="checkbox"/> Chiropractor <input type="checkbox"/> Physiotherapist <input type="checkbox"/> RMT <input type="checkbox"/> Other
Did They provide Relief?	<input type="checkbox"/> Y <input type="checkbox"/> N How/What
Any Pins, Wires or Artificial Jts	<input type="checkbox"/> Y <input type="checkbox"/> N
Are You On Any Medications?	<input type="checkbox"/> Y <input type="checkbox"/> N
Energy Level	<input type="checkbox"/> Low <input type="checkbox"/> Average <input type="checkbox"/> High
Do you Feel Stressed?	<input type="checkbox"/> Y <input type="checkbox"/> N Cause?
Regular Exercise?	<input type="checkbox"/> Y <input type="checkbox"/> N Type?
Regular Sleep?	<input type="checkbox"/> Y <input type="checkbox"/> N How many hours per day?
Computer Use?	<input type="checkbox"/> Y <input type="checkbox"/> N How many hours per day?
Mobile Device Use?	<input type="checkbox"/> Y <input type="checkbox"/> N How many hours per day?
Notes:	

Please indicate conditions you are experiencing or have experienced:

<p><u>Cardiovascular</u></p> <ul style="list-style-type: none"> <input type="checkbox"/> high blood pressure <input type="checkbox"/> low blood pressure <input type="checkbox"/> chronic congestive heart failure <input type="checkbox"/> heart attack <input type="checkbox"/> stroke / CVA <input type="checkbox"/> phlebitis / varicose veins <p><u>Respiratory</u></p> <ul style="list-style-type: none"> <input type="checkbox"/> chronic cough <input type="checkbox"/> shortness of breath <input type="checkbox"/> bronchitis <input type="checkbox"/> asthma <input type="checkbox"/> emphysema <p><u>Infections</u></p> <ul style="list-style-type: none"> <input type="checkbox"/> hepatitis <input type="checkbox"/> skin conditions <hr/> <ul style="list-style-type: none"> <input type="checkbox"/> TB <input type="checkbox"/> HIV <input type="checkbox"/> Other 	<p><u>Women</u></p> <ul style="list-style-type: none"> <input type="checkbox"/> pregnant, due: _____ <input type="checkbox"/> menstrual pain <input type="checkbox"/> PMS <input type="checkbox"/> hormonal imbalances <input type="checkbox"/> gynecological conditions <hr/> <p><u>Other Conditions</u></p> <ul style="list-style-type: none"> <input type="checkbox"/> Diabetes type 1 <input type="checkbox"/> Diabetes type 2 <input type="checkbox"/> allergies/hypersensitivities <hr/> <ul style="list-style-type: none"> <input type="checkbox"/> epilepsy <input type="checkbox"/> cancer, where? <hr/> <ul style="list-style-type: none"> <input type="checkbox"/> skin conditions <hr/> <ul style="list-style-type: none"> <input type="checkbox"/> arthritis <input type="checkbox"/> osteoarthritis <input type="checkbox"/> rheumatoid <input type="checkbox"/> family history of arthritis <input type="checkbox"/> chronic fatigue <input type="checkbox"/> fibromyalgia <input type="checkbox"/> depression <input type="checkbox"/> anxiety <input type="checkbox"/> bipolar <input type="checkbox"/> dizziness <input type="checkbox"/> fatigue <input type="checkbox"/> memory loss <input type="checkbox"/> sleep problems <input type="checkbox"/> concentration problems 	<p><u>Head / Neck</u></p> <ul style="list-style-type: none"> <input type="checkbox"/> history of headaches <input type="checkbox"/> history of migraines <input type="checkbox"/> vision problems / vision loss <input type="checkbox"/> ear problems / hearing loss <p><u>Musculoskeletal</u></p> <ul style="list-style-type: none"> <input type="checkbox"/> strains: _____ _____ <input type="checkbox"/> sprains: _____ _____ <input type="checkbox"/> fractures: _____ _____ <input type="checkbox"/> dislocations: _____ _____ <input type="checkbox"/> loss of sensation: _____ _____ <input type="checkbox"/> degenerative disc: _____ _____ <input type="checkbox"/> scoliosis <input type="checkbox"/> nerve problems: _____ _____
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Additional Information That May Be Relevant:

INFORMED CONSENT TO MASSAGE THERAPY TREATMENT

I understand that the Registered Massage Therapist is providing massage therapy services within their scope of practice as defined by the College of Massage Therapists of Ontario (CMTO).

I hereby consent for my therapist to treat me with massage therapy for the above noted purposes including such assessments, examinations and techniques, which may be recommended by my therapist.

I acknowledge that the therapist is not a physician and does not diagnose illness or disease or any other physical or mental disorder. I clearly understand that massage therapy is not a substitute for a medical examination. It is recommended that I attend my personal physician for any ailments that I may be experiencing. 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.

I acknowledge and understand that the therapist must be fully aware of my existing medical conditions. I have completed my medical history form as provided by my therapist and disclosed to the therapist all of those medical conditions affecting me. It is my responsibility to keep the massage therapist updated on my medical history. The information I have provided is true and complete to the best of my knowledge.

I authorize my therapist to release or obtain information pertaining to my condition(s) and/or treatment to/from my other caregivers or third party payers.

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 treatment as proposed by my therapist from time to time, to deal with my physical condition and for which I have sought treatment. I understand that at any time I may withdraw my consent and treatment will be stopped.

I understand the cancellation policy, and that I must provide at least 24 hours notice of cancellation of an appointment. I understand that I may be charged the full fee for a missed appointment if proper cancellation notification is not provided to the clinic.

Payment for services rendered is due upon receipt.

Client Name _____

Signature of Client/Guardian _____

Therapist Name John Maynard

Therapist Signature _____

Date Signed _____

Notes:

Health history updates:

Update1 _____

Update2 _____

Update 3 _____

Update 4 _____