



Massage Therapy Health History Form

It is important to maintain an accurate health history to ensure that the treatment provided is safe for you. If your health status changes in the future please let me know. All information gathered for this treatment is confidential except as required or allowed by law. You have the right to access personal information in your clinical file and you will be asked to provide written authorization for the release of any information.

Name: _____ Date: _____
 Address: _____ City: _____ Postal Code: _____
 Date of Birth: _____ Telephone Number: (Day) _____ (Evening) _____
 E-mail address: _____ Occupation: _____
 What is your primary complaint: _____
 Have you received treatment by an RMT before? Yes / No How did you find our clinic? _____
 Would you consider your general health status to be (please circle one): excellent / good / fair / poor ?

Please indicate if you have experienced or are currently experiencing any of the following:

Respiratory	Skin	Other
<input type="checkbox"/> Chronic Cough <input type="checkbox"/> Shortness of Breath <input type="checkbox"/> Bronchitis <input type="checkbox"/> Asthma <input type="checkbox"/> Emphysema <input type="checkbox"/> Family History of Respiratory Problems Onset: _____ Cardiovascular <input type="checkbox"/> High Blood Pressure <input type="checkbox"/> Low Blood Pressure <input type="checkbox"/> CCHF <input type="checkbox"/> MCI (Heart Attack) <input type="checkbox"/> Phlebitis/Varicose Veins <input type="checkbox"/> CVA (Stroke) <input type="checkbox"/> Pacemaker or Similar <input type="checkbox"/> Heart Disease <input type="checkbox"/> Poor Circulation <input type="checkbox"/> Family History of Cardiovascular Problems Onset: _____	<input type="checkbox"/> Bruise Easily <input type="checkbox"/> Skin Conditions: _____ Infections <input type="checkbox"/> Respiratory <input type="checkbox"/> Warts (current?) _____ <input type="checkbox"/> Hepatitis <input type="checkbox"/> TB <input type="checkbox"/> Herpes <input type="checkbox"/> HIV <input type="checkbox"/> Skin Conditions Hearing/Vision <input type="checkbox"/> Vision Problems <input type="checkbox"/> Vision Loss <input type="checkbox"/> Hearing Problems <input type="checkbox"/> Hearing Loss Women <input type="checkbox"/> Genealogical Conditions _____ <input type="checkbox"/> Pregnant (due: ____/____/____)	<input type="checkbox"/> Loss of Sensation <input type="checkbox"/> Diabetes (onset: ____/____/____) <input type="checkbox"/> Allergies/Hyper-sensitivity Reactions <input type="checkbox"/> Epilepsy <input type="checkbox"/> Cancer <input type="checkbox"/> Arthritis: Dr. Diagnosed? Y/N Affected areas: _____ <input type="checkbox"/> Family History of Arthritis <input type="checkbox"/> History of Headaches/Migranes <input type="checkbox"/> Osteoperosis <input type="checkbox"/> Mental Illness <input type="checkbox"/> Internal Pins/Wires (location: _____) <input type="checkbox"/> Artificial Limb/ Special Equipment: _____ <input type="checkbox"/> Digestive Conditions <input type="checkbox"/> Haemophilia <input type="checkbox"/> Constipation <input type="checkbox"/> Liver <input type="checkbox"/> Gall Bladder <input type="checkbox"/> Kidney <input type="checkbox"/> Sinus

Check off the location of any areas of soft tissue/joint discomfort and describe it's nature:

<input type="checkbox"/> Neck _____	<input type="checkbox"/> Arms _____
<input type="checkbox"/> Shoulders _____	<input type="checkbox"/> Legs _____
<input type="checkbox"/> Upper Back _____	<input type="checkbox"/> Knees _____
<input type="checkbox"/> Mid-Back _____	_____
<input type="checkbox"/> Low Back _____	<input type="checkbox"/> Feet _____
	Other _____



Current Medications (and the condition they treat): _____

Surgery (& Date): _____

Injury (& Date): _____

Primary Health Care Physician: _____

Address: _____ Phone Number (____) ____ - _____

Present Involvement in Other Health Care (please specify) : _____

Other Medical Conditions (or information of note): _____

Massage Therapy Consent Form & Cancellation Policy

(Renewed annually)

I understand that my massage therapist is providing me with information pertinent to my treatment including the benefits and possible side effects. I may stop or request modifications to the treatment at any time. Alternate courses of treatment where applicable and relevant will be explained to me.

I understand that I will be **charged a cancellation fee of \$50.00 for missed appointments unless 24 hours notice** is given. While the first missed appointment may be excused, the cancellation fee will apply to any subsequent missed appointments. I am aware of the cost of this treatment.

I have read the policy and consent and agree to each. It is also assumed that by signing this consent form I agree to ongoing treatment if my therapist and I deem it advisable.

Name (Please Print) _____ Date: _____

Signature: _____ Date: _____
(If 16 years and older)

Parent Signature: _____ Date: _____
(If under 16 years old)

You may withdraw or alter your consent at any time for any reason.