

### 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**

- Chronic Cough
  - Shortness of Breath
  - Bronchitis
  - Asthma
  - Emphysema
  - Family History of Respiratory Problems
- Onset: \_\_\_\_\_

**Cardiovascular**

- High Blood Pressure
  - Low Blood Pressure
  - CCHF
  - MCI (Heart Attack)
  - Phlebitis/Varicose Veins
  - CVA (Stroke)
  - Pacemaker or Similar
  - Heart Disease
  - Poor Circulation
  - Family History of Cardiovascular Problems
- Onset: \_\_\_\_\_

**Skin**

- Bruise Easily
- Skin Conditions: \_\_\_\_\_

**Infections**

- Respiratory
- Warts (current?) \_\_\_\_\_
- Hepatitis
- TB
- Herpes
- HIV
- Skin Conditions

**Hearing/Vision**

- Vision Problems
- Vision Loss
- Hearing Problems
- Hearing Loss

**Women**

- Genealogical Conditions \_\_\_\_\_
- Pregnant (due: \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_) \_\_\_\_\_

**Other**

- Loss of Sensation
- Diabetes
- (onset: \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_) \_\_\_\_\_
- Allergies/Hyper-sensitivity Reactions
- Epilepsy
- Cancer
- Arthritis: Dr. Diagnosed? Y/N
- Affected areas: \_\_\_\_\_
- Family History of Arthritis
- History of Headaches/Migranes
- Osteoperosis
- Mental Illness
- Internal Pins/Wires
- (location: \_\_\_\_\_)
- Artificial Limb/ Special Equipment: \_\_\_\_\_
- Digestive Conditions
- Haemophilia
- Constipation
- Liver
- Gall Bladder
- Kidney
- 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"/> Feet _____  |
| <input type="checkbox"/> Low Back _____   | 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.**