Confidential Health History
Registered Massage Therapy

CASE HISTORY

An accurate health history is important to ensure that it is safe for you to receive a massage treatment. If your health status changes in the future, please let me know. All information gathered for this treatment is confidential except as required by law or except to facilitate diagnosis (assessment) or treatment. You will be asked to provide written authorization for the release of any information.

Name: ____ Date: _________________________

Address:_______________________________City: ______________________ Postal Code:______________

Home Telephone: ________________ Bus. Telephone: _________________ Cell phone: ____________________

Date of Birth: __________________ Occupation: ____

Medical Doctor: ____________________________________ Address: _______________________________

Where did you hear about our clinic? : ____

What brings you in for a Massage? : ____

Have you received Massage therapy before? □ Yes □ No

Did a health practitioner refer you for massage therapy? □ Yes □ No

If yes, please provide their name and address. ____

Do you have Extended Health Care Insurance for Massage Therapy? □ Yes □ No

Please indicate conditions you are currently experiencing with a ☑ or have previously experience with a ☒

Cardiovascular
□ high blood pressure
□ low blood pressure
□ chronic congestive heart failure
□ phlebtitis/varicose veins
□ stroke / CVA
□ pacemaker or similar device
□ heart disease
□ heart attack
□ history of deep vein thrombosis (blood clot)

Infections
□ hepatitis
□ infectious skin conditions
□ HIV
□ herpes
□ TB
□ infectious respiratory conditions

Head/Neck
□ history of headaches
□ history of migraines
□ vision loss
□ ear problems
□ hearing loss
□ vertigo
□ sinus

Is there a family history of Cardiovascular problems? □ Yes □ No

OTHER CONDITIONS

Respiratory
□ chronic cough
□ shortness of breath
□ bronchitis
□ asthma
□ emphysema

Is there a family history of Respiratory conditions?
□ Yes □ No

□ skin conditions, what? ___________
□ loss of sensation, where?_________
□ diabetes, onset: ________________
type? ____________________
□ allergies/hypersensitivity to what:
____
type of reaction:_________________
□ epilepsy
□ cancer, where? __________________
□ arthritis

Is there a family history of Arthritis? □ Yes □ No

Women

□ pregnant, due: ___________
□ gynecological conditions, what? ____________________
____

Overall, how is your general health? ____

Current Medications	**Condition it treats**
_____________________	_____________________
_____________________	_____________________
_____________________	_____________________

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

Over please⇨

Surgery – date: ____
Nature: ____

Injury – date: ____
Nature: ____

Do you have any internal pins, wires, artificial joints or special equipment?
□ Yes □ No
what? __________________________
where? _________________________

Do you have any other medical conditions? (e.g. digestive conditions, hemophilia, osteoporosis, mental illness?)
□ Yes □ no
What? ____

Muscle Pain and Tension

NECK	**SHOULDER**	**ARM**	**LEG**	**BACK**	**GLUTEALS**
□ right □ left □ front □ back	□ right □ left □ front □ back	□ right □ left □ front □ back	□ right □ left □ front □ back	□ upper □ mid □ lower	□ right □ left

What kind of pressure do you like? □ Deep □ Medium □ Light □ Not sure

CONSENT TO TREATMENT

I, ___________________________________, of my own free will, consent to be treated for the following condition:
(Name)

____
(Description of condition/major complaint)

I acknowledge that my therapist has provided me with such information as is pertinent to the treatment for the above listed complaint. Alternative course of treatment (where applicable) have been explained to me, as well as the possible benefits, risks and side effects, if any, with regard to my therapists proposed treatment plan.

I feel that I fully understand what is involved in the proposed massage treatment plan and what the possible consequences of not having the treatment may be.

I acknowledge that, for the purpose of integrated therapy, the following areas may be addressed during the course of treatment.

___ Head ___ Neck/Shoulders ___ Arms ___ Back ___ Upper Chest
___ Abdomen ___ Gluteals ___ Legs/Hips ___ Hands ___ Feet

I understand that I may change my mind regarding any aspect of my treatment at any time and upon informing my therapist of my decision, I may withdraw consent with the intent to alter or discontinue the treatment.
In compliance with the Consent to Treatment Act, I provide my full, voluntary, informed consent to treatment.

Client Name: ____

Client Signature: ____

Date: ____

Therapist Signature/Witness: ____

LATE AND/OR MISSED APPOINTMENTS

If for any reason an appointment must be rescheduled, 24 **hours notice is required so that we may use this time to serve others in need.**
If you are late for an appointment for whatever reason, the fee for your appointment will remain as originally scheduled, and the duration will remain as time that is left. We excel at providing prompt service and the most value for your massage appointments; therefore appointments cannot be extended for lateness. It is your responsibility to be at your appointment on time. **Appointments missed or cancelled with less that 24 hours notice will be considered a "No Show Appointment" which are subject to the fee for the original scheduled appointment**. This fee is the responsibility of the patient and cannot be billed to the Insurance Company.

Client Signature: ______________________________________