Health History Form

The information request below will assist us in treating you safely. Feel free to ask any questions about the information being requested. Please note that all information provided below will be kept confidentially unless allowed or required by law. Your written permission will be required to release any information.

Name: ______________________ Phone # ______________
Address: ____
Occupation: ______________________ Date of Birth: ____________
Have you received massage therapy before? ☐ Yes ☐ No
Did a health care practitioner refer you for massage therapy? ☐ Yes ☐ No
If yes, please provide their name and address. ______________________
____

Please indicate conditions you are experiencing or have experienced:

Cardiovascular
- high blood pressure
- low blood pressure
- chronic congestive heart failure
- heart attack
- phlebitis / varicose veins
- stroke/CVA
- pacemaker or similar device
- ☐ heart disease

is there a family history of any of the above? Yes No

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

is there a family history of any of the above? Yes No

Infections
- hepatitis
- skin conditions
- TB
- HIV
- herpes

Other Conditions
- loss of sensation, where? ____________
- diabetes, onset: ____________
- allergies/hypersensitivity to what? ____________
- type of reaction: ____________
- epilepsy
- cancer, where? ____________
- skin conditions, what? ____________
- arthritis

is there a family history of arthritis? Yes No

Head/Neck
- history of headaches
- history of migraines
- vision problems
- vision loss
- ear problems
- hearing loss

Women
- pregnant, due: ____________
- gynaecological conditions, what? ____________

Overall, how is your general health? ____________

Primary Care Physician: ____________

Address: ____________
____

Current Medications: ____________
condition it treats: ____________
____

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

Surgery – date ____________
nature: ____________

Injury – date ____________
nature: ____________

Do you have any other medical conditions? (e.g. digestive conditions, haemophilia, osteoporosis, mental illness) Yes No
what? ____________

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

What is the reason you are seeking massage therapy? Please include the location of any tissue or joint discomfort.
____
____
____

Notes:

Date of initial Health History:____________
Update 1 ____________
Update 2 ____________
Update 3 ____________
Update 4 ____________

Consent to Massage Therapy Treatment

It is important for you to consider the benefits, risks and alternatives to the treatment options offered by your massage therapist and to make an informed decision about proceeding with treatment.

Benefits

Massage therapy treatment has been demonstrated to be effective for complaints of the neck, back and other areas of the body caused by nerves, muscles, joints and related tissues. Treatment by your massage therapist can relieve pain including headaches, altered sensation, muscle stiffness and spasm. It can also increase mobility, improve function, and reduce or eliminate the need for drugs or surgery.

Risks

The risks associated with massage therapy vary according to each patient's condition as well as the location and type of treatment.

The risks include:

- Temporary worsening of symptoms: Usually any increase in pre-existing symptoms of pain or stiffness will last only a few hours to a few days.
- Skin irritation or burn: Skin irritation or a burn may occur in association with the use of some types of heat therapy. Skin irritation should resolve quickly. A burn may leave a permanent scar.
- Sprain or strain: Typically, a muscle or ligament sprain or strain will resolve itself within a few days or weeks with some rest, protection of the affected area and other minor care.

Alternatives

Alternatives to massage therapy may include consulting with other health professionals. Your massage therapist may also prescribe rest without treatment, or exercise with or without treatment.

Questions or Concerns

You are encouraged to ask questions at any time regarding your assessment and treatment. Bring any concerns you have to the massage therapist's attention. If you are not comfortable, you may stop treatment at any time.

Please be involved in and responsible for your care. Inform your massage therapist immediately of any changes in your condition.

I hereby acknowledge that I have discussed with the massage therapist the assessment of my condition and the treatment plan. I understand the nature of the treatment to be provided to me. I have considered the benefits and the risks of treatment, as well as the alternatives to treatment. I hereby consent to massage therapy treatment as proposed to me.

I understand that the massage therapist is providing massage therapy services within the scope of their practice. I understand that the therapist is not a doctor and does not diagnose illness or disease or any

other physical or mental disorders. I clearly understand that massage therapy is not a substitute for a chiropractic or medical examination.

Privacy

All personal information provided by you to our office will handled according to the Health Information Act and Freedom of Information.

Extended Health Care

Most extended health care programs will pay part of massage fees. We will be happy to provide third party billing to our patients but please note that the patient is ultimately responsible for submitting the claim to their insurance company. This is an agreement between the patient and the insurance company, not between your massage therapist and insurance company. Any problems with submission will result in the full amount of the service being charged to the patient.

Patient Co-operation

We will set up a specific course of treatment for you. A certain number of treatments in a set amount of time are required for us to get the results we desire. Therefore, if you need to change an appointment, it is necessary for you to reschedule to make up that appointment within the week. This will enable you to maintain your treatment schedule. You must realize that a missed appointment may increase the number of visits required for you to reach optimum health.

No smoking, alcohol, or illicit substance use is allowed on the premises. Treatment will be refused if the patient is, or is suspected to be, under the influence of any of the aforementioned substances.

Appointment times/ Cancellation Policy

We strive to run on time. If your condition changes or you have a new concern that you need to discuss, please call the office so that we may book the appropriate amount of time for you. If you are 10 minutes late or more for your appointment time, you will be asked to reschedule out of respect for the other patients who have arrived on time. **We require 24 hours notice of a cancellation to avoid paying the full fee. Patients will be billed for appointments missed without 24 hours notice**.

The information I have provided is true and complete to the best of my knowledge.

____

Patient Name (please print)

____ __________________________

Signature of Patient (or Legal Guardian) Date