Health History Form

The information requested 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 confidential unless allowed or required by law. Your written permission will be required to release any personal information.

Name: _____ Phone# _____ Cell Phone# _____
Address: _____ City: _____ Postal Code: _____
Occupation: _____ Date of Birth: _____
E-Mail: _____ How did you hear about our office? _____
Primary Care Physician: _____ Phone# _____
Reason for seeking massage therapy: _____
Did a health care practitioner refer you for massage therapy? ☐Yes ☐ No
Have you received massage therapy before? ☐ Yes ☐ No

Please indicate conditions you are experiencing or have experienced:

Cardiovascular:
- ☐ High blood pressure
- ☐ Low blood pressure
- ☐ Chronic congestive heart failure
- ☐ Heart attack
- ☐ Stroke/ CVA
- ☐ Phlebitis/ Varicose veins
- ☐ Pacemaker or similar device
- ☐ Heart disease

Is there a family history of any of the above? ☐ Yes ☐ No
Specify: _____

Respiratory:
- ☐ Asthma
- ☐ Bronchitis
- ☐ Emphysema
- ☐ Chronic cough
- ☐ Shortness of breath

Is there a family history of any of the above? ☐Yes ☐No
Specify: _____

Infections:
- ☐ Hepatitis
- ☐ Tuberculosis
- ☐ HIV
- ☐ Herpes

Muscular/Neurological:
- ☐ Headaches/migraines
- ☐ TMJ dysfunction
- ☐ Hearing loss
- ☐ Vision problems
- ☐ Loss of sensation

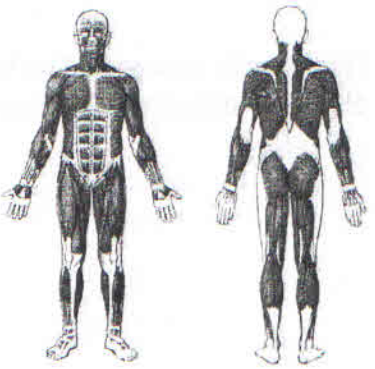
Other Conditions:
- ☐ Diabetes
  Onset: _____
- ☐ Allergies
  Specify: _____
- ☐ Skin conditions
  Specify: _____
- ☐ Epilepsy
- ☐ Cancer
- ☐ Arthritis

Is there a family history of arthritis? ☐Yes ☐No

Women:
- ☐ Pregnant
  Due Date: _____
- ☐ Gynaecological conditions
  Specify: _____

Miscellaneous:
Do you have any internal pins, wires etc? ☐Yes ☐ No
Specify: _____
_____

Do you have any other medical conditions? ☐Yes ☐No
Specify: _____



Please indicate areas of discomfort above.

Current medications/ Condition it treats: _____
_____
Surgery/ Date: _____
_____

Consent Form

At any time before or during the treatment process, please feel free to ask your therapist any questions or concerns you may have regarding your treatment.

I _____ of my own free will consent to be treated for the above stated areas of concern.

I acknowledge that the therapist will/has provided me with such information as is pertinent to treatment for my above listed complaints.

Alternative courses of treatment, where applicable and relevant, have been explained to me, as well as the possible risks and side effects of the proposed treatment plan.

I fully understand the consequences of having treatment/not having treatment.
I understand that I may stop the treatment at any time before or during the treatment process.

CANCELLATION POLICY: We require 24 hours notice of appointment cancellation, otherwise full treatment fee may be charged to you by your therapist. Thank you.

Print Name _____

Signature _____

Date _____

This form is recognized by the College of Massage Therapists of Ontario to contain the elements necessary to ensure compliance with the Standards of Practice