Massage Therapy Health History Form

PERSONAL INFORMATION

Name:_____ Date:_____
Address:_____ City:_____
Postal Code:_____ Birth Date: (m/d/y)_____
Telephone: (home)_____ (cell)_____
(work)_____
Occupation:_____ Referred by:_____
Email: _____ Subscribe to newsletter? (circle) YES NO

HEALTH INFORMATION

Emergency Contact Name:_____ Telephone#:_____

Name of Doctor: _____ Telephone:_____
Address: _____ City:_____

Current Medications: _____
_____
Surgeries (please list and date): _____
_____
Please list the presence of internal pins, wires, artificial joints or special equipment:
_____
Name of chiropractor: _____ Telephone:_____
List other therapies (i.e. Physiotherapy): _____
_____
Have you ever received a professional massage? (please circle) YES NO
What is your main concern today regarding your massage therapy treatment (goal):
_____
_____
Family History of:

☐ Heart disease ☐ Auto-immune disorders
☐ Cancer ☐ Epilepsy

GENERAL INFORMATION

Have you ever been in a Motor Vehicle Accident? (please circle) YES NO
6 months ago 1 year ago 2 years ago or more
Recreational or sporting activities: _____
Posture assumed throughout the day: _____
List stress reduction activities: _____

Health History

Please check off appropriate boxes for past and present conditions.

Musculo-skeletal

- ☐ neck R___ L___
- ☐ back
  upper__middle__lower__
- ☐ shoulder R___ L___
- ☐ elbow R___ L___
- ☐ wrist R___ L___
- ☐ hip R___ L___
- ☐ knee R___ L___
- ☐ ankle R___ L___
- ☐ jaw/TMJ

Sensation

- ☐ pain
- ☐ soreness
- ☐ ache
- ☐ burning
- ☐ numbness/tingling
- ☐ restricted range of motion

- ☐ tendonitis
- ☐ bursitis
- ☐ osteoarthritis
- ☐ rheumatoid arthritis
- ☐ sprain/strain
- ☐ headaches
  tension____
  migraine____
  sinus____
- ☐ other _____

Circulatory

- ☐ heart disease
- ☐ varicose veins
- ☐ blood clots
- ☐ high blood pressure
- ☐ low blood pressure
- ☐ lymphedema
- ☐ breathing difficulty
- ☐ sinus problems
- ☐ allergies
- ☐ chronic congestive heart failure
- ☐ myocardial infarction
- ☐ stroke
- ☐ phlebitis
- ☐ pacemaker
- ☐ other _____

Skin

- ☐ allergies (skin irritation)
- ☐ rashes
- ☐ athletes foot
- ☐ warts
- ☐ other (infectious) _____
  _____

Respiratory

- ☐ chronic cough
- ☐ shortness of breath
- ☐ emphysema
- ☐ asthma
- ☐ other _____

Digestive

- ☐ constipation
- ☐ diverticulitis
- ☐ irritable bowel syndrome
- ☐ other _____

Reproductive

- ☐ pregnant (____weeks)
- ☐ gynaecological conditions
- ☐ PMS
- ☐ other _____

Infectious Disease

- ☐ hepatitis
- ☐ TB
- ☐ HIV
- ☐ other _____

Nervous System

- ☐ herpes
- ☐ shingles
- ☐ chronic pain
- ☐ fatigue
- ☐ sleep disorder
- ☐ other _____

Other

- ☐ cancer
- ☐ epilepsy
- ☐ haemophilia
- ☐ eating disorder
- ☐ depression
- ☐ drug/alcohol addiction
- ☐ nicotine addiction
- ☐ diabetes
- ☐ vision loss
- ☐ hearing loss
- ☐ CFS/fibromyalgia
- ☐ thrombophilia
- ☐ other _____

REGISTERED MASSAGE THERAPY CONSENT FORM

In keeping with the Health Care Consent Act, 1996, it is my choice to receive massage therapy. I understand that an accurate health history is important to ensure my safety with regards to receiving a massage treatment. I am also aware that an assessment is required for each client. I understand that all information that I provide for this treatment is confidential, except as required or allowed by law or except to facilitate diagnosis (assessment) or treatment. I also understand that I will be asked to provide written authorization for release of any information.

I am aware that it is not necessary to remove all articles of clothing for treatment, and that I can decide to remove only the clothing which makes me feel comfortable. I will give consent to my massage therapist to treat only those body parts for which I give permission. I agree to communicate with my massage therapist at any time that I feel that my well-being is being compromised. I am aware that I may terminate treatment at any point during the massage, at my discretion and without reason. I am aware that I may experience possible side effects from the massage treatment, such as, temporary muscular discomfort (24-48 hours post treatment), bruising and temporary dizziness or headache.

PRIVACY POLICY

Your knowledge and consent are required before we may collect, use, or disclose your personal information except in rare circumstances (i.e. subpoena, medical emergency, and debt collection). If you have a question on any of this, please ask. To view the full privacy policy document, copies are available in office and at www.therapeutichealingandwellness.com.

I consent to the collection, use, or disclosure of my information as described in Therapeutic Healing and Wellness Centre's patient Privacy Policy.

Signature: _____ Date: _____

For those under the age of 16:

Parental/Guardian Signature: _____ Date: _____