Massage Therapy Health History Form

PERSONAL DATA

Name:___________________________________ Date:______________________________
Address:______________________________________ City:______________________________
Postal Code:____________________ Birth Date: (m/d/y)____________________________
Telephone: (home)______________________ (work)______________________________
Occupation:____________________________ Referred by:____________________________
Email: ________________________________ Subscribe to newsletter? (circle) YES NO

HEALTH INFORMATION

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
- ☐ back
  upper__middle__lower__
- ☐ shoulder R___ L____
- ☐ elbow
- ☐ wrist
- ☐ hip
- ☐ knee
- ☐ ankle
- ☐ 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 ________________

Infectious Disease

- ☐ hepatitis
- ☐ TB
- ☐ HIV
- ☐ other _____________

Skin

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

Digestive

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

Nervous System

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

Respiratory

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

Reproductive

- ☐ pregnant (____weeks)
- ☐ gynaecological conditions
- ☐ PMS
- ☐ 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.

Signature: ___________________________________ Date: __________________________
(16 years of age or older)

Parental/Guardian Signature: _________________________ Date: _________________________