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

NAME:_______________________________________ EMAIL: ______________________________________

Address: ____Phone: _______________________

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 the 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 ________

INFORMED CONSENT

This letter is to inform you of your rights as a patient. In Ontario, massage therapy is regulated under the regulated Health Professionals Act. This act empowers patients such as yourself, with regards to their health care treatments. What this means is that you have the right to make decisions regarding your health care. If you are uncomfortable or unsatisfied with your treatment plan you have the right to alter or terminate it at anytime. If you have any questions regarding your treatment or your health, please feel free to ask.

Please inform your therapist of any major health concerns that are not listed on the case history form. By doing so, your therapist is able to design an appropriate treatment plan and provide you with the best possible care.

During your massage a variety of therapeutic techniques may be used. If you are uncomfortable with any of these techniques, please let your therapist know. Some people may experience mild side effects from their first massage. The side effects should subside as you continue the course of your treatment plan. These side effects may include mild tissue tenderness, headaches, or fatigue. A minority of people experience side effects while most people feel relaxed and rejuvenated.

Your personal health information will be treated with respect, sensitivity, and privacy. Any information regarding your health history or massage treatments will not be disclosed to another party without your written consent. We are committed to protecting your privacy.

In consideration of other clients, we require an eight (8) hour advanced cancellation of massage treatments. There will be a full-service charge for non-cancelled appointments.

I hereby consent to the massage therapy treatments as described by my therapist. I understand the desired effects and possible side effects of my treatment. I recognize that my therapist and I are partners in my Health Care Program, and I agree to take responsibility for my health care and lifestyle choices.

Signature: ____________________________________ Date: _______________