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 confidential unless allowed or requested by law. Your written permission will be required to release any information. _____ Client Initials.

Name:_____ Phone #: _____ Cell #:_____

Address:_____ City:_____ Postal Code:_____

Occupation:_____ Date of Birth: _____

How were you referred to our clinic? _____

Name & address of the Practitioner who referred you : _____

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
- ☐ Phlebitis/Varicose Veins
- ☐ Stroke/CVA
- ☐ Pacemaker or similar device
- ☐ Heart Disease

Respiratory
- ☐ Chronic Cough
- ☐ Shortness of breath
- ☐ Bronchitis
- ☐ Asthma
- ☐ Emphysema

Is there 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 condition, what?: _____
- ☐ Arthritis

Is there 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? (ie. 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? Include areas of tissue or joint pain.
_____ _____

Treating practitioner:_____

Initial health history:_____
Update 1_____
Update 2_____
Update 3_____
Update 4_____

General Information

Extended Health Care Clients: Please call your insurance provider to ensure that massage therapy is covered through your extended health care plan. Inquire as to details of this coverage (What is the total per year? Do you have a "per visit limit"?). Due to confidentiality reasons, only you can obtain this information from your provider. The provider will not give this information to our office directly. It is also the responsibility of the client to notify us of any changes in extended health care coverage.

Cancellation Policy: To avoid a service charge, kindly notify us of any cancellations 24 hours prior to your appointment.

Consent to Treatment

I, _____ *[print name],* understand that the massage I receive is provided for the basic purpose of relaxation and relief of muscular tension. If I experience any pain or discomfort during this session, I will immediately inform the therapist so that the pressure and/or strokes may be adjusted to my level of comfort. I further understand that massage should not be construed as a substitute for medical examination, diagnosis, or treatment, and that I should see a physician, or other qualified medical specialist for any mental or physical ailment that I am aware of. I understand that massage therapists are not qualified to perform spinal or skeletal adjustments, diagnose, prescribe, or treat any physical or mental illness, and that nothing said in the course of the session given should be construed as such. Because massage should not be performed under certain medical conditions, I affirm that I have stated all my known medical conditions, and answered all questions honestly. I agree to keep my therapist updated as to any changes in my medical profile and understand that there shall be no liability on the therapist's part should I fail to do so. I understand and appreciate the above information as well as the treatment I am about to receive and give my full informed consent to treatment.

CLIENT SIGNATURE _____ **DATE** _____

THERAPIST SIGNATURE _____ **DATE** _____