



massage therapy clinic

Patient Health History Form

First & Last Name: _____ DOB (DD/MM/YY): ___/___/___ M F

Address: _____ City/Province: _____ Postal Code: _____

Occupation: _____ * Email (Please Print) _____

Tel #: (_____) _____ Work: (_____) _____ Cell: (_____) _____

Emergency Contact Name: _____ Tel # (_____) _____

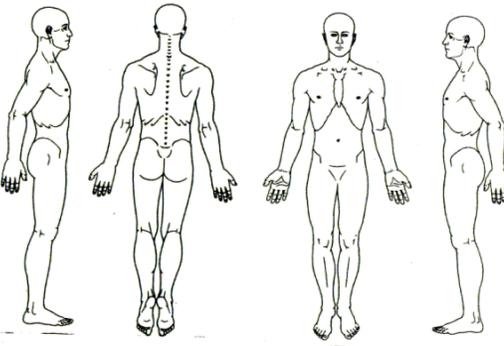
Family Physician Name : _____ Tel # (_____) _____

Family Physician Address: _____

What is your current complaint? _____ For How long ? _____

Currently receiving treatments from any health care practioner ? No Yes, _____

Indicate in the pictures below the location(s) of your complaint



Was the onset Sudden Gradual Following a trauma No specific reason noted

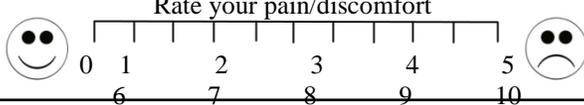
How often is the discomfort present?
 Intermittent (25% or less) Occasional (25%-50%)
 Frequent (50%-75%) Constant (75%-100%)

What makes your condition **BETTER**?
 Lying down Sitting Standing Walking
 Exercise Rest Nothing

What makes your condition **WORSE**?
 Lying down Sitting Standing Walking
 Exercise Rest Nothing

I have no problems and feel well. I'm interested in strategies and care to help optimize my health

Rate your pain/discomfort



Is your primary concern related to a motor vehicle accident ?
 Yes No , If YES Date: (DD/MM/YYYY): ___/___/___

List any previous injuries/surgeries/serious illnesses

<u>Injuries/Surgeries/Serious Illnesses</u>	<u>Date</u>

Please list any medications you are currently taking and the condition(s)

<u>Medication</u>	<u>Condition</u>	<u>Dosage</u>

Have you taken any pain-killers, anti-inflammatory, muscle relaxants or mood altering medications in the past 2 hrs?
 No Yes What and how much? _____

For Office Use:	Updated: _____
Updated: _____	Updated: _____
Updated: _____	Updated: _____
Updated: _____	Updated: _____

Please Indicate the conditions that you have experienced or experiencing

Cardiovascular

- High blood pressure
- Low blood pressure
- Chronic congestive heart failure
- Heart attack
- Phlebitis/Varicose veins
- Stroke/CVA
- Pacemaker or similar device
- Heart disease
- Dizziness/Vertigo
- Seizures

Is there any family history of any of the above? Yes No

Respiratory

- Asthma
 - Bronchitis
 - Emphysema
 - Chronic cough
 - Shortness of breath
- Is there any family history of any of the above? Yes No

Digestive

- Constipation
- Chrones disease
- Colitis
- Irritable bowel syndrome
- Ulcers

Head and Neck

- History of headaches
- History of migraines
- Vision problems
- Vision loss
- Hearing problems
- Hearing loss

Muscle/Joint

- Neck
- Spine
- Upper back
- Mid back
- Lower back
- Shoulders
- Elbow
- Wrist/Hand
- Hip
- Knee
- Ankle/Foot
- Internal pins/Wires
- Artificial joints/Special equipments Describe: _____

Other

- Loss of sensation
Where? _____
- Diabetes
Since when? _____
Type _____
- Allergies
What? _____
- Hypersensitivity
What? _____
- Cancer
Type/Location: _____
- Arthritis
Type? _____
Family history? Yes No
- Nerve lesion
- Any Nerve related diseases
- Epilepsy
- Hemophilia
- Fibromyalgia
- Chronic fatigue
- Scoliosis
- Polio/Post polio
- Osteoporosis
- Gout
- Any other diseases
Describe: _____

Infectious Conditions

- Skin condition
Describe: _____
- Respiratory conditions
Describe: _____
- Hepatitis A B C D E
- HIV
- TB
- Herpes

Women

- Pregnancy
Due date: _____
- Previous pregnancy complications: _____
- Menopausal problems: _____
- Menstrual problems: _____
- Any gynecological conditions: _____

Skin Conditions

- Eczema
- Psoriasis
- Rash
- Warts
- Open sores

Have you had Massage Therapy / Physiotherapy / Chiropractic before? No Yes

Did a healthcare practitioner refer you for Massage Therapy / Physiotherapy or Chiropractic? No Yes

If Yes, please provide their contact information: _____

Overall, how is your general health? _____

Is there any additional information that you would like to provide?

Signature

Date

Confidentiality, Consent and Office Policies

Confidentiality:

By signing this form, you have agreed that you understand that all information gathered for this treatment remains confidential except as required or allowed by law or to facilitate assessment or treatment. You also agree that you understand that the therapist may discuss my case with peers who are under the same confidentiality clause in order to provide the best treatment possible. No other personal information will be disclosed other than that which is directly associated with your care / treatment.

Your written consent will be required should any information be released to any third party, e.g. insurance companies, family physician.

Please read the following:

- I have filled out a complete and updated Patient Health History form and have had an opportunity to ask any questions that I may have to clarify and better understand why an accurate health history is needed.
- My therapist has explained to me what the nature and purpose of the proposed assessment/reassessment, treatment and or remedial plans, prior to the commencement of treatment. I understand that results are not guaranteed.
- I am aware that I may discontinue the assessment, reassessment, treatment, and/or remedial exercise plan at any time.
- I understand and am informed that the practice of Massage Therapy involves some risks to treatment, including, but not limited to, pain and soreness. I understand that my therapist will, at the best of his/her abilities, explain expected benefits of the proposed treatment, as well as anticipate and inform me of any possible risks and complications.

I also confirm that I have the ability to accept or reject this care of my own free will and choice and that I am not an agent of any private, local, provincial, or federal agency attempting to gather information without so stating.

- **I understand the fee structure posted at the clinic and accept full responsibility for prompt payment.**
- **Being late for the scheduled appointment will result in a shorter treatment and I will be responsible to pay for the scheduled time period. I also understand that scheduled treatment time includes treatment preparation, interview, assessment and documentations required by regulatory body and/or insurance companies so that I do not expect hands on treatment for the entire scheduled time period; however the therapist will try his level best to provide maximum hands on treatment within the time frame.**
- **I understand that I am responsible for paying the full appointment fee if I do not give 24 hours notice of change or cancellation.**
- I, _____ (Print Name) have read the above consent. I have also had an opportunity to ask questions about its content and by signing below I give my consent to the therapist to proceed with assessment, re-assessment, treatment, and or remedial exercise plan. I intend this consent to cover the entire course of treatment for my present condition. I also consent to add my email to our newsletter campaign.

Signature

Date

Consent for Assessment and Treatment of Sensitive Areas

I, _____ (name), have requested assessment and/or treatment by this Registered Massage Therapist (RMT) _____ (name) for treatment of the clinically relevant areas indicated below (please initial):

___ Buttocks (gluteal muscles)

___ Chest Wall Muscles

___ Upper Inner Thigh(s)

___ Breast (s)

The RMT has explained the following to me and I fully understand the proposed assessment and/or treatment:

- The nature of the assessment, including the clinical reason(s) for assessment of the above area(s) and the draping methods to be used
- The expected benefits of the assessment
- The potential risks of the assessment
- The potential side effects of the assessment
- That consent is voluntary
- That I can withdraw or alter my consent at any time.

I voluntarily give my informed consent for the assessment and/or treatment as discussed and outlined above.

Client Name (print): _____

Client Signature: _____ Date: _____

Ongoing Treatment:

I am aware that the treatment of the above indicated area(s) is part of a treatment plan which has been discussed with me by my RMT. I confirm that, on the following date(s), the RMT has reviewed the treatment plan and I provide my informed consent.

Client Signature: _____ Date: _____

Client Signature: _____ Date: _____