

HEALTH HISTORY

DATE _____

An accurate health history is important to ensure you receive a safe massage treatment. If your health status changes please let your therapist know. All the information you share is confidential except as required or allowed by law or to facilitate assessment or treatment. If a release of information is considered appropriate, your permission is required. Registered Massage Therapy is a health profession regulated by College of Massage Therapists of Ontario. This treatment is not a substitute for a visit to an M.D. but rather should be complementary to whatever other care you require or are receiving.

FIRST NAME: _____ LAST NAME: _____

ADDRESS: _____ EMAIL: _____

PHONE: (home) _____ (work) _____ OCCUPATION: _____

DATE OF BIRTH: _____ AGE: _____ Reason for your visit today: _____

Referred by: _____ Have you seen a Massage Therapist before? _____

If yes, for what reason _____

Physician's Name _____ Address _____

Current medication, vitamins, supplements & conditions your M.D. is treating _____

Are you currently seeing any other health care professionals?

Chiropractor _____ Physiotherapist _____ Psychotherapist _____ Massage Therapist _____

Other _____

For what conditions and how often _____

Please list surgeries, motor vehicle accidents, illnesses with dates: _____

Do you exercise or play sports regularly? If yes, what do you do?

EMERGENCY CONTACT: _____ PHONE: _____

NAME _____ DATE _____

Please check any current conditions ("P" if past condition; "C" if current condition)

CARDIOVASCULAR

- High Blood Pressure
- Low Blood Pressure
- Chronic Congestive Heart Failure
- Heart Disease
- History of Myocardial Infarction
- Stroke / CVA
- Angina
- Phlebitis
- Atherosclerosis
- Pacemaker or similar device

INFLAMMATORY

- Rheumatoid Arthritis
- Osteoarthritis
- Lupus
- Reiter's Syndrome
- Scleroderma
- Polymyalgia
- Fibromyalgia
- Ankylosing Spondylitis
- Gout

Immunological condition (please specify) e.g., MS, HIV etc _____

Cancer (where & when?) _____

Internal Pins / Artificial Joints / Wires (where?) _____

Infectious Skin Conditions _____

RESPIRATORY

- Chronic Cough
- Bronchitis
- Asthma
- Shortness of Breath
- Emphysema
- Smoker

PELVIC

- PID
- Endometriosis

DIGESTIVE

- Crohn's Disease
- Irritable Bowel Syndrome
- Colitis
- Prolonged Constipation
- Prolonged Diarrhea
- Hiatus Hernia
- Reflux
- Ulcers

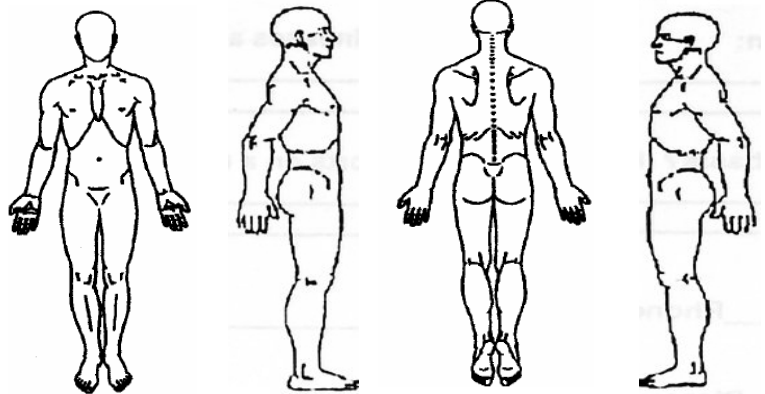
NERVOUS

- Loss of Sensation
- Epilepsy
- Multiple Sclerosis
- Buerger's Disease
- Neuralgia
- Neuritis
- Spastic Paralysis
- Flaccid Paralysis

OTHER

- Tuberculosis
- Hepatitis (A, B, C, D)
- Hemophilia
- Varicose Veins
- Diabetes
- Kidney Disease
- Thyroid Disease
- Insomnia
- Fainting / Dizziness
- Migraines
- Headaches
- Nausea
- Bruise Easily
- Jaw Problems
- Chronic Fatigue
- Environmental Sensitivities
- Osteoporosis

Please indicate areas of pain or discomfort on the diagrams



I certify that the information I have provided is correct and accurately reflects my present health status
Signature _____ **Date** _____

Client Name: _____

Date: _____

At any time during or before the massage, you can choose to alter or stop the treatment. If you have any questions or concerns about massage therapy or your treatment, please talk to your therapist.

During the treatment, you will be draped (covered) with sheets. The draping will only uncover the area being worked on at the time. You may choose to remove or leave on clothing according to your level of comfort.

You may experience some soreness, discomfort, or a headache the day after your massage. If this happens, it is important to let the therapist know so that your next treatment can be modified. Your therapist will have suggestions on how to prevent the discomfort from occurring.

We require 24 hours notice when canceling or rescheduling an appointment. In the event of a missed appointment, you will be charged the price for the scheduled appointment.

- I have fully disclosed all medical conditions that I am aware of, and understand that it will be my responsibility to inform my Therapist of any changes in my health status.
- I acknowledge that this information is confidential, and that no personal data shall be released to anyone (following the laws of confidentiality).

I have read the above information fully and wish to proceed with the treatment.

Signature of Client: _____

Date: _____