Confidential Health History Form

General Information

Name _____ Date _____

Address _____ City _____

Province _____ Postal Code _____

Occupation _____

Phone Numbers – Home _____Cell _____ Work _____

Consent to contact you via E-mail or Cell phone if needed regarding appointments:

Yes – please contact via E-mail or No Yes – please contact via Cell phone or No

How did you hear about this clinic/massage therapist?

_____

Health History

General Health Status _____
Primary Care Physician _____
Address/Phone # _____

Emergency Contact

Name _____Relationship _____ Phone#_____

Current Medications – Please provide Name of medication and condition for which it is prescribed. Include Homeopathic remedies and vitamins.

_____
_____
_____

Allergies –

Meds/Foods/Environmental_____

Massage Treatments -

Have you received massage therapy before? Yes or No
If yes, please document for what reason ie. Relaxation massage/Specific condition/Craniosacral Therapy/ Therapeutic Breast Massage/Abdominal Visceral Manipulation -

_____

Reason for Massage therapy today _____
Type of Pain _____ Does the pain radiate? Yes or No
If yes, where does that pain radiate? _____
What aggravates situation? _____
What relieves situation? _____

Please list any major operations, major injuries or accidents with date/timeframe

_____
_____

Health Care Practitioners -

Do you currently see any other health care professionals?
____ Naturopathic Doctor ____Chiropractor ____ Physiotherapist ____ Osteopath ____ Other
If so, for what reason and how often: _____

_____
_____

Please circle the conditions you have had or are currently experiencing:

Muscles/Joints/Nerves

- Neck
- Jaw/TMJ
- Shoulder
- Arm
- Wrist/Hand
- Upper Back
- Mid Back
- Low Back
- Hip
- Leg/Thigh
- Knee
- Ankle
- Feet

- Pain/Stiffness/Limited Range of Motion: _____
- Swelling
- Sprain/Strain
- Numbness/Loss of Sensation
- Carpal Tunnel Syndrome
- Repetitive Strain Injury
- Sports/Work related Injury
- Degenerative Disc – location: _____
- Tendonitis: _____
_____

- Bursitis
- Fibromyalgia
- Arthritis (Rheumatoid/Osteo)
- Osteoporosis
- Chronic Fatigue Syndrome
- Seizures/Epilepsy
- Sciatica
- Nervousness/Anxiety
- Depression
- Other: _____

Head and Neck

- Headaches:

Location - _____
Type - _____
Frequency - _____

- Sinus problems
- Ear problems
- Hearing loss
- Vertigo/Dizziness
- Eye problems
- Vision loss

Other: _____

Skin

- Allergies: _____
- Rashes:

Location - _____

- Contagious condition ie. Plantars warts _____
- Eczema
- Dermatitis
- Psoriasis
- Bruise easily

Digestive/Elimination

- Constipation
- Diarrhea
- Ulcer
- Liver
- Gallbladder
- Kidney
- Bladder
- IBS
- Crohns
- Colitis

Other: _____
_____

Cardiovascular/Other

- Low blood pressure
- High blood pressure
- Poor circulation
- Congestive heart failure
- Varicose veins/Phlebitis
- Chest pain/Angina
- Blood clots
- Edema/Swelling
- Heart disease
- Hardening of the Arteries
- Stroke/CVA/Heart Attack
- Pacemaker or similar device

Other:

- Diabetes – Onset: _____
- Cancer – Location: _____
_____
- Special Equipment (cane/crutches)_____
- Pins/Wires/Plates: where _____
- Prosthesis/Artificial Joints _____

Immune System/Respiratory

- Smoker (Current)

If smoker at any time – how long? _____
When did you quit? _____
_____
Device used to quit? _____

- Asthma

Type of Puffer - _____
_____

- Chronic cough
- Bronchitis
- Shortness of breath
- Emphysema
- SLE (Lupus)
- MS
- Hepatitis – Type: _____
- HIV/AIDS

Other information:
_____
_____
_____
_____

Women

- Are you pregnant?
- # of weeks along: _____
- Due Date: _____
- Irregular or painful menstrual cycles
- Experiencing changes in normal cycle
- Fibrocystic cysts
- Tenderness in breast tissue prior to or during cycle
- Endometriosis
- Perimenopause symptoms
- Menopause

Other information - _____
_____
_____
_____

Any other conditions not listed above: _____

Family history of any of the above conditions: _____

Consent Form

Initial Massage Therapy Appointment – 60 minutes:

If you are able to print the forms from the website then please come with your health history completed with as much detail as possible, even old injuries are important to note. If you are unable to print the forms from the website, then please arrive 15 minutes prior to your appointment to complete the documents. Bring a list of your medications so I can review what you are taking and if it can have an effect on the treatment modalities I am planning on using with you. Be prepared to discuss at length your past health issues.

Basic assessments will be done to determine your overall body alignment, any visible restrictions or tendencies to one side or another, any discrepancies in symmetry, etc. This will be followed by orthopedic tests if needed depending on your condition or complaint. For example, if you are coming in with tingling or numbness in your fingers, I am going to perform several tests with you and palpate your fingers, wrist, arm, shoulder and neck to determine the possible cause BEFORE we begin treatment. Once I have completed the assessment, then we will discuss the treatment plan for this appointment. The time allotted for this portion can take between 10-20 minutes depending on the situation, and is essential to forming a safe, accurate and effective treatment.

Following your consent to the treatment plan for this session, I will leave the room to wash my hands which will allow you the privacy to undress to your level of comfort for the treatment. Upon my return to the room the treatment portion of the session will begin.

The treatment will end 5 minutes early to allow you time to get up safely from the table, get dressed again and for us to discuss future treatment plans, self-care (stretches and exercises, use of heat/cold therapy, etc.) and to complete the payment process.

Ongoing Treatments – 30/45/60 minutes:

A brief discussion and assessment process to include any changes since last treatment including any soreness change in pain or range of motion. Please advise of any changes in your health, digestion, medications, sleep patterns, exercise routines, new injuries and stress levels as they can have an effect on the results you may or may not be achieving. This will assist in whether changes are made to the treatment plan or follow a similar treatment as the initial session. This takes approximately 5 minutes.

The treatment will follow and the session will end 5 minutes early to allow you time to get up safely from the table, get dressed and for us to discuss future treatment plans, self-care (stretches and exercises, use of heat/cold therapy, etc.) and to complete the payment process.

Please read carefully, and sign:

I certify that the information I have provided is true, accurate and complete to the best of my knowledge. I understand the information I have provided is confidential and will not be released without my written consent. I consent to therapeutic massage treatment. I understand that my appointment time has been set-aside exclusively for me. I understand if I am running late my Therapist will treat me for the remainder of the scheduled treatment time.

I understand that * **24 hours notice is required** * to cancel or reschedule all future appointments (emergency/sickness exempt). I understand that there will be a 50% * **missed appointment fee** * charged to me for 1st missed appointment, subsequent appointments will be charge full session fee due to insufficient cancellation notice.

Signature: _____ Date: _____