KAWARTHACARE
Wellness Centre

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Health History for Massage Therapy

Please take a moment to fill out this health history form as completely as possible. The information gathered through your health history provides your massage therapist with necessary information to treat you safely. Please feel free to ask questions about why we are requesting this information. The information you provide us with will be kept confidential unless you submit a written request for us to release your information or if required by law.

First Name _____ Occupation _____

Last Name _____ Date of birth _____ *(DD/MM/YY)*

Contact information:

Street address _____ Home phone _____

City _____ Province _____ Cell phone _____

Postal Code _____ Work phone _____

Email _____ Call me first at: ◯ Home ◯ Cell ◯ Work

Emergency contact (Name) _____ Emergency phone _____

Family physician:

Name _____ Phone _____

Address _____

Have you received massage therapy before ◯ No ◯ Yes

Were you referred for massage therapy from a health care practitioner? ◯ No ◯ Yes **If yes, please provide their name and address:**

_____

What is your primary complaint? _____

Can you describe it? (circle one or more) ☐ DULL ☐ SHARP ☐ SHOOTING ☐ ACHY ☐ NUMB ☐ TINGLING ☐ STIFF

Pain scale: (Low) 1----------5----------10 (High) **Does the pain radiate anywhere?** _____

Does anything aggravate/relieve your symptoms? _____

When did your symptoms begin? _____

Is this condition interfering with (circle all that apply): ☐ WORK ☐ SLEEP ☐ DAILY ROUTINE ☐ ACTIVITIES

Have you seen any other health care practitioner concerning this complaint?

☐ Medical Dr. ☐ Chiropractor ☐ Physiotherapist ☐ Massage Therapist

Have you seen changes? _____

Surgery/injuries/hospitalization: (date, past & current symptoms) _____

_____

Do you have any internal pins/wires/artificial joints: _____

Are you currently taking any medications: (please list them and the condition they treat) _____

Lifestyle:

Energy levels: ☐ Low ☐ Average ☐ High

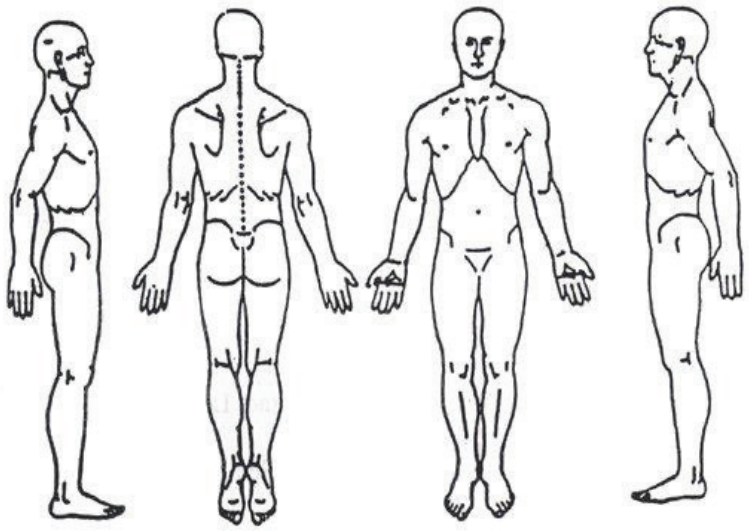
Do you feel stressed? ☐ No ☐ Yes Cause? _____

Regular exercise? ☐ No ☐ Yes Type _____ Frequency _____

Regular sleep habits? ☐ No ☐ Yes

Computer use? ☐ No ☐ Yes How many hours per day? _____

Please indicate on the diagram below the location(s) of your symptoms:



Have you experienced any of the following conditions? If so, please indicate which ones:

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
- ☐ Smoker?

Head and Neck

- ☐ History of headaches
- ☐ History of migraines
- ☐ Vision problems
- ☐ Vision loss
- ☐ Ear problems

Soft Tissue/Joint Pain

- ☐ Neck
- ☐ Upper back/shoulders
- ☐ Arms/hands
- ☐ Mid back
- ☐ Low back
- ☐ Hips
- ☐ Legs
- ☐ Knees
- ☐ Feet
- ☐ Other _____

Infections

- ☐ Hepatitis
- ☐ Skin conditions/rash
- ☐ TB
- ☐ HIV
- ☐ Herpes

Women

- ☐ Pregnant. Due:
- ☐ Gynaecological issues.
  What:_____
  _____

Other

- ☐ Loss of sensation. Where:_____
- ☐ Diabetes. Onset: _____
- ☐ Allergies. To what:_____
- ☐ Epilepsy
- ☐ Cancer. Where:_____
- ☐ Fibromyalgia
- ☐ Swelling in the ankles
- ☐ Bruise easily
- ☐ Arthritis
- ☐ Digestive conditions
- ☐ Hemophilia
- ☐ Osteoporosis
- ☐ Mental illness
- ☐ Dizziness/Fainting
- ☐ Other:_____
  _____

Gastrointestinal

- ☐ Diarrhea
- ☐ Indegstion/heartburn
- ☐ Constipation
- ☐ Other:_____

How would you rate your overall health? (Circle) ◯ FAIR ◯ GOOD ◉ EXCELLENT

What are your goals for your massage therapy treatment? _____

How did you hear about our clinic ? REFERRAL BY : _____

_____ ☐ Doctor ☐ Advertising ☐ Website Other (please specify) _____

INFORMED CONSENT TO MASSAGE THERAPY TREATMENT

I understand that the Registered Massage Therapist is providing massage therapy services within their scope of practice as defined by the College of Massage Therapists of Ontario (CMTO).

I hereby consent for my therapist to treat me with massage therapy for the above noted purposes including such assessments, examinations and techniques, which may be recommended, by my therapist.

I acknowledge that the therapist is not a physician and does not diagnose illness or disease or any other physical or mental disorder. I clearly understand that massage therapy is not a substitute for a medical examination. It is recommended that I attend my personal physician for any ailments that I may be experiencing. I acknowledge that no assurance or guarantee has been provided to me as to the results of the treatment. I acknowledge that with any treatment there can be risks and those risks have been explained to me and I assume those risks.

I acknowledge and understand that the therapist must be fully aware of my existing medical conditions. I have completed my medical history form as provided by my therapist and disclosed to the therapist all of those medical conditions affecting me. It is my responsibility to keep the massage therapist updated on my medical history. The information I have provided is true and complete to the best of my knowledge.

I authorize my therapist to release or obtain information pertaining to my condition(s) and/or treatment to/from my other caregivers or third party payers.

I have read the above noted consent and I have had the opportunity to question the contents and my therapy. By signing this form, I confirm my consent to treatment and intend this consent to cover the treatment discussed with me and such additional treatment as proposed by my therapist from time to time, to deal with my physical condition and for which I have sought treatment. I understand that at any time I may withdraw my consent and treatment will be stopped.

I understand the cancellation policy, and that I must provide at least 24 hours notice of cancellation of an appointment. I understand that I may be charged the full fee for a missed appointment if proper cancellation notification is not provided to the clinic.

Client Name _____ Signature of Client/Guardian _____

Therapist name_____ Date Signed _____

Notes:

Date of initial health history: _____

Update 1_____

Update 2_____

Update 3_____

Update 4_____