

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 confidentially unless allowed or requested by law. Your written permission will be required to release any information.

Last Name: _____ • First Name: _____
 Address: _____ Town/Prov.: _____ Postal Code: _____
 Date of Birth: Day () Month () Year () • Age: _____
 Tel. (Home): (_____) _____ - _____ • (Work): (_____) _____ - _____ Ext: _____
 (Cell): (_____) _____ - _____ • E-mail: _____
 Yes, you may send me e-mail reminders, statements and clinic changes No, do not contact me by e-mail
 Occupation: _____
 How did you hear about us? _____
 Have you received massage therapy before? YES NO
 Did a health care practitioner refer you for a massage therapy? YES NO
 If yes, please provide their name and address: _____

Please indicate conditions you are experiencing or have experienced:

<p><u>Cardiovascular</u></p> <p><input type="radio"/> High blood pressure <input type="radio"/> Low blood pressure <input type="radio"/> Chronic congestive heart failure <input type="radio"/> Heart attack <input type="radio"/> Phlebitis <input type="radio"/> Stroke/CVA <input type="radio"/> Pacemaker or similar device <input type="radio"/> Heart disease</p> <p>Is there a family history of any of the Above? YES <input type="radio"/> NO <input type="radio"/></p> <p><u>Respiratory</u></p> <p><input type="radio"/> Chronic cough <input type="radio"/> Shortness of breath <input type="radio"/> Bronchitis <input type="radio"/> Asthma <input type="radio"/> Emphysema</p> <p>Is there a family history of any of the above? YES <input type="radio"/> NO <input type="radio"/></p>	<p><u>Infections</u></p> <p><input type="radio"/> Hepatitis <input type="radio"/> Skin conditions <input type="radio"/> TB <input type="radio"/> HIV <input type="radio"/> Herpes</p> <p><u>Other Conditions</u></p> <p><input type="radio"/> Loss of sensation Where? _____ <input type="radio"/> Diabetes, onset: _____ <input type="radio"/> Allergies/Hypersensitivity To what? _____ Type of reaction? _____ <input type="radio"/> Epilepsy <input type="radio"/> Cancer <input type="radio"/> Skin Condition What? _____ <input type="radio"/> Arthritis</p> <p>Is there a family history of Arthritis? YES <input type="radio"/> NO <input type="radio"/></p>	<p><u>Head/Neck</u></p> <p><input type="radio"/> History of headaches <input type="radio"/> History of migraines <input type="radio"/> Vision problems <input type="radio"/> Vision loss <input type="radio"/> Ear problems <input type="radio"/> Hearing loss</p> <p><u>Women</u></p> <p><input type="radio"/> Pregnant? YES <input type="radio"/> NO <input type="radio"/> Due date: _____ <input type="radio"/> Gynaecological conditions What? _____</p> <p>Overall, how is your general health? _____</p> <p>Primary Care Physician: _____</p> <p>Address: _____</p>
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<p>Current Medications: _____ Condition it treats: _____ Are you currently receiving treatment from another health care professional YES <input type="radio"/> NO <input type="radio"/> If yes, for what? _____</p> <p><u>Surgeries</u></p> <p>Date: _____ Nature: _____ Date: _____ Nature: _____</p> <p><u>Injuries</u></p> <p>Date: _____ Nature: _____ Date: _____ Nature: _____</p>	<p>Do you have any other medical conditions? (e.g. digestive conditions, haemophilia, osteoporosis, mental illness) YES <input type="radio"/> NO <input type="radio"/> What? _____</p> <p>Do you have any internal pins, wires, artificial joints or special equipment? YES <input type="radio"/> NO <input type="radio"/> What? _____ Where? _____</p> <p>What is the reason you are seeking massage therapy? Please include the location of any tissue or joint discomfort _____ _____</p>
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Notes:

<p>Date of initial Health History: _____</p> <p>Update 1: _____</p> <p>Update 2: _____</p> <p>Update 3: _____</p> <p>Update 4: _____</p>

Informed Consent for Massage Therapy

Massage Therapy care is based on promoting health, preventing illness and helping individuals attain and maintain the highest levels of wellness possible by integrating the art and science of Massage Therapy through responsible, compassionate, and respectful touch.

The value of nurturing touch during the delivery of Massage Therapy is a well established and vital element. The therapist acknowledges all facets of their clients being, including their physical, emotional, mental and spiritual aspect.

Your comfort and trust in this clinic is very important in providing an optimal client/therapist relationship. Before, during, or after therapy, we encourage you to communicate to the therapist about any aspect of treatment.

Treatment will be provided only when there is reasonable expectation that it will be advantageous to the client.

Proper draping is always provided to ensure safety, comfort and privacy for all clients. Clients are asked to disrobe in privacy and prepare themselves on the table. You may choose to remove or leave clothing on, according to your own comfort level. Treatment will be modified to accommodate this. The Massage Therapist respects your right to modify, refuse or terminate treatment, regardless of prior consent given.

The Massage Therapist respects the client's right to an informed and voluntary consent regarding care and treatment and to obtain consent of the client before providing treatment. This clinic respects the confidentiality of all client information, unless disclosure is required by law or court order. Information will not be released otherwise, unless a client's written consent is obtained.

Cancellation Policy

Your care is very important to this office and as a result, an appointment time is reserved for your treatment. If necessary to reschedule or cancel an appointment, please attempt to provide our office with 24 hours notice. However, please also note the following

- An appointment cancelled within 3 hours of scheduled treatment will be subject to an administration fee of \$15.00. However, should you reschedule your appointment within 7 days, this fee will be waived.
- Should you miss an appointment, you will be subject to the full cost of the treatment.

I, _____ have read the above information and understand my rights to consent of treatment.

Signature: _____ • Date: _____