Ryan Murray
91 Laval St
Gatineau, QC J8X 3H4
Tel : (819) 771-8700

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:______________ Postal Code:____________
Date of Birth: Day ( ) Month ( ) Year ( ) E-mail:______________________
Tel. (Home):______________ (Work):______________x_____ (Cell):______________
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:______________________________
____

❑ Yes, you may contact me by e-mail for information regarding the clinic. ❑ No, do not contact me by e-mail.

Please indicate conditions you are experiencing or have experienced:

Cardiovascular
○ High blood pressure
○ Low blood pressure
○ Chronic congestive heart failure
○ Heart attack
○ Phlebitis
○ Stroke/CVA
○ Pacemaker or similar device
○ Heart disease

Is there a family history of any of the Above? YES ○ NO ○

Respiratory
○ Chronic cough
○ Shortness of breath
○ Bronchitis
○ Asthma
○ Emphysema

Is there a family history of any of the above? YES ○ NO ○

Infections
○ Hepatitis
○ Skin conditions
○ TB
○ HIV
○ Herpes

Other Conditions
○ Loss of sensation
Where? ______________________
○ Diabetes, onset: ______________
○ Allergies/Hypersensitivity
To what? ______________________
Type of reaction? ______________
○Epilepsy
○ Cancer______________________
○ Skin Condition
What? ______________________
○Arthritis

Is there a family history of Arthritis? YES ○ NO ○

Head/Neck
○ History of headaches
○ History of migraines
○ Vision problems
○ Vision loss
○ Ear problems
○ Hearing loss

Women
○ Pregnant? YES ○ NO ○
Due date:______________
○ Gynaecological conditions
What? ______________________

Overall, how is your general health?
____

Primary Care Physician:
____

Address: ______________________
____

Current Medications:______________________________
Condition it treats:______________________________
Are you currently receiving treatment from another health care professional YES ○ NO ○
If yes, for what? ______________________________
____

Surgeries
Date:__________ Nature:______________________
Date:__________ Nature:______________________

Injuries
Date:__________ Nature:______________________
Date:__________ Nature:______________________

Do you have any other medical conditions? (e.g. digestive conditions, haemophilia, osteoporosis, mental illness)
YES ○ NO ○ What? ______________________

Do you have any internal pins, wires, artificial joints or special equipment? YES ○ NO ○
What? ______________________________
Where? ______________________________

What is the reason you are seeking massage therapy? Please include the location of any tissue or joint discomfort
____
____

Notes:

Initial Health History: __________
Update 1: ____________ ______
Update 2: ____________ ______
Update 3: ____________ ______

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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: ____________________________