

Michael Hodgson, RMT

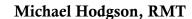
Update 1: Update 2: Update 3: Update 4:

407 Laurier Avenue W. • Ground Floor • Ottawa • ON • K1R 7Y7
Tel: (613) 233-8700 • Fax: (613) 233-8782

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:	
			Postal Code:
Date of Birth: Day () Month ()			1 ostal code.
Tal (Hama):	rear () Ag	Worls). (E
Tel. (Hollie): ()	• ((WOIK): () _	Ext:
(Cell): ()			
☐Yes, you may send me e-mail remind		-	
Occupation:			
How did you hear about us?			
Have you received massage therapy be	fore? YES O N	0 0	
Did a health care practitioner refer you			0
If yes, please provide their name and a	•	• •	
<u> </u>			
Please indicate conditions you are		nave experienced	
Cardiovascular O High blood pressure	Infections O Hapatitis		Head/Neck
O Low blood pressure	O Hepatitis O Skin conditions		O History of headaches O History of migraines
O Chronic congestive heart failure	O TB	5	O Vision problems
O Heart attack	O HIV		O Vision loss
O Phlebitis	O Herpes		O Ear problems
O Stroke/CVA	o Herpes		O Hearing loss
O Pacemaker or similar device	Other Conditions	<u>s</u>	
O Heart disease	O Loss of sensation		<u>Women</u>
	Where?		O Pregnant? YES O NO O
Is there a family history of any of the	O Diabetes, onset	:	Due date:
Above? YES O NO O	O Allergies/Hypersensitivity		O Gynaecological conditions
D	To what?		What?
Respiratory	To what? Type of reaction?		Overall, how is your general health?
O Chronic cough O Shortness of breath	OEpilepsy		
O Bronchitis	O CancerO Skin Condition		Primary Care Physician:
O Asthma			Timary Care I mysician.
O Emphysema	OArthritis		Address:
Is there a family history of any of the	Is there a family h	istory of Arthritis?	
above? YES O NO O	YES O NO O	istory of Artificias.	
Current Medications:		Do you have any of	her medical conditions? (e.g. digestive
Condition it treats:			hilia, osteoporosis, mental illness)
Are you currently receiving treatment from	another health care		at?
professional YES O NO O			
If yes, for what?			ternal pins, wires, artificial joints or special
		equipment? YES O NO O	
Surgeries		What?	
Date:Nature:		Where'?	
Date:Nature:		What is the reason :	you are seeking massage thereny? Dlesse
<u>Injuries</u>			you are seeking massage therapy? Please of any tissue or joint discomfort
Date: Nature:			of any tissue of joint disconnort
Date:Nature:			
Notes:			Date of initial Health
			History:





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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 it's necessary to reschedule or cancel an appointment, please provide the office with 24 hours notice.

If an appointment is **cancelled** or **rescheduled** with **less than 24 hours notice**, the full treatment fee will be charged to the patient, and in this case an insurance receipt will not be issued. If the treatment is rescheduled for the same business day, this fee will be waived (rescheduling for the same day is dependent upon therapist availability).

Thank you for respecting your	therapist's time and agreeing to this policy.	
I,to consent of treatment.	have read the above information and understand my rig	
Signature:	• Date:	