



Initial	_____
Update 1	_____
Update 2	_____
Update 3	_____
Update 4	_____
Update 5	_____

## MASSAGE THERAPY HEALTH HISTORY

An accurate health history is necessary to ensure you receive the safest and most effective treatment possible. All information collected herein, or discussed during the course of your treatment, is absolutely confidential (except where release is required by law). Your written consent will be necessary before any information is released to a third party. Your personal information is stored according to the regulations set forth by the Personal Health Information Protection Act and the Personal Information Protection and Electronic Documents Act.

Name:	Date of Birth:	Today's Date:
Address:	Postal Code:	
Home Phone:	Work Phone:	
e-mail:		
Occupation:	Have you had massage therapy before? .... Y / N	
How did you hear about our clinic?		
Were you referred by a Health Professional? .... Y / N		
Address of referring professional:		
What is your primary reason for today's visit?		
How do you feel about your overall health?		

### Please indicate any areas where you have discomfort:

- |                                  |                                |                              |                                   |                                   |                                |
|----------------------------------|--------------------------------|------------------------------|-----------------------------------|-----------------------------------|--------------------------------|
| <input type="radio"/> Upper Back | <input type="radio"/> Head     | <input type="radio"/> Throat | <input type="radio"/> Shoulders   | <input type="radio"/> Pelvis      | <input type="radio"/> Buttocks |
| <input type="radio"/> Mid Back   | <input type="radio"/> Face/Jaw | <input type="radio"/> Chest  | <input type="radio"/> Arms/Elbows | <input type="radio"/> Legs/Knees  | <input type="radio"/> Abdomen  |
| <input type="radio"/> Lower Back | <input type="radio"/> Neck     | <input type="radio"/> Breast | <input type="radio"/> Wrist/Hands | <input type="radio"/> Ankles/Feet |                                |
| <input type="radio"/> Other:     |                                |                              |                                   |                                   |                                |

Primary Care Physician:	Current Medication(s):	
Address:	For what?	
Phone:	Surgery:	Date:
(May we contact if necessary?)	Y / N	Nature:
Present involvement in other healthcare?	Y / N	Injury : Date:
Please Explain:	Nature:	

**Please check any condition you are currently experiencing, or have ever experienced:**

- headaches/migraines       shortness of breath       phlebitis       family history of arthritis
- vision problems       chronic cough       varicose veins       arthritis
- contact lenses       emphysema       stroke / CVA      type: (OA/RA/Other)
- dizziness       asthma       diabetes       warts / athlete's foot
- hearing problems       bronchitis       epilepsy       skin conditions/ infections
- numbness       cchf       cancer      explain:
- pins & needles       high blood pressure       tuberculosis       allergies / sensitivities:
- insomnia       low blood pressure       hepatitis      type:
- depression       heart attack or disease       HIV/AIDS       pregnant - due date:
- mental health condition       hemophilia       gynaecologic condition       digestive problems

**Additional Information:**

*Other medical conditions for which you have been diagnosed, or are being treated?*

*Of Special Note (i.e. presence of internal pins, wires, artificial joints, special equipment):*

*\* If at any time your health status changes, please inform your therapist.*

**Office Policies:**

*\*Please be sure to sign as recognition that you have read and understood the following points regarding your visit to this clinic:*

Informed Consent: I am aware that it is my choice to receive massage therapy. I understand that treatments may include assessment of my soft tissue and joints, use of oils or gels, applications of heat or cold, and stretching or strengthening exercises as indicated by my condition. I understand that my therapist will discuss the treatment plan with me to ensure that I receive a safe and effective treatment. I know it is my right to discuss any component of my treatment with the therapist and that my consent can be rescinded at any time.

Scent-Free Policy: Please refrain from wearing scented products (perfumes, cologne, hairspray, body lotions) to the clinic. Many patients have allergies and severe chemical sensitivities.

Cancellation Policy: Appointments missed or cancelled without 24 hour notice will be subject to a cancellation/missed appointment fee of \$45.00 (payable at next visit or within 10 days of the missed appointment - whichever comes first).

**SIGNATURE**

**DATE**