HEALTH HISTORY FORM FOR REGISTERED MASSAGE THERAPY

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R.M.T., OSTEOPATHY (Current Study)

Name: _____

Date of Birth: _____ Age: _____

Address: _____

City: _____ Postal Code: _____

Phone Number Home: _____ Cell: _____

E-mail Address: _____

Occupation: _____

Family Doctor: _____ Phone Number: _____

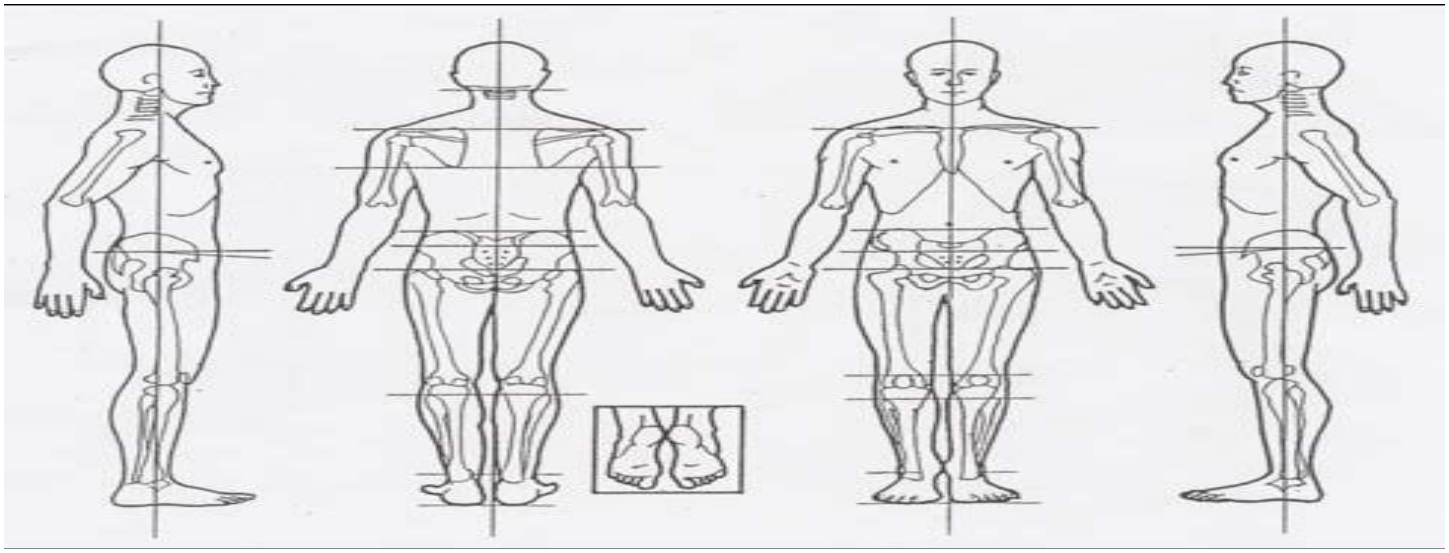
Referred By: _____

Primary Concern / Complaint: _____

Have you had Massage Therapy before? □ Yes □ No

How do you describe your present state of health? _____

Indicate Location of Pain, Discomfort, Numbness, Tingling and/or Tightness below:



Please List Any Previous Injuries and/or Accidents:

1. _____ Date: _____

2. _____ Date: _____

3. _____ Date: _____

Please List Any Previous Surgeries:

1. _____ Date: _____

2. _____ Date: _____

Please List Any Medications Taken In the Past 6 Months:

1. _____ Purpose: _____

2. _____ Purpose: _____

Please Indicate Conditions You Are or Have Experienced:

CARDIOVASCULAR
- □ High Blood Pressure
- □ Low Blood Pressure
- □ Heart Disease
- □ Heart Attack
- □ Stroke
- □ Varicose Veins
- □ Bruise Easily
- □ Pacemaker

RESPIRATORY
- □ Chronic Cough
- □ Breathing Difficulty
- □ Bronchitis
- □ Asthma
- □ Emphysema

Do you smoke? Yes No

INFECTIONS
- □ Hepatitis A B C
- □ Tuberculosis
- □ HIV / AIDS
- □ Herpes

SKIN
- □ Eczema
- □ Psoriasis
- □ Acne
- □ Plantar Warts
- □ Athletes Foot

DIGESTIVE / URINARY
- □ Constipation
- □ Diarrhea
- □ Crohn's / Colitis
- □ Ulcers
- □ Gallbladder
- □ Liver
- □ Kidney Infection
- □ Bladder Infection

HEAD & NECK
- □ Headache
- □ Migraine
- □ Whiplash
- □ Jaw Pain
- □ Ear Pain
- □ Hearing Loss
- □ Vision Loss/Other Concerns

WOMEN
- □ Menstrual Concerns / Pain
- □ Endometriosis
- □ Menopausal Concerns
- □ Hysterectomy
- □ Pregnant

Due Date? _____

Number of Children _____

MUSCLE / JOINT
- □ Muscle Strain
- □ Ligament Sprain
- □ Tendonitis
- □ Bursitis
- □ Arthritis OA RA
- □ Osteoporosis
- □ Herniated Disc
- □ Scoliosis
- □ Dislocation
- □ Fracture
- □ Pins/Wires

OTHER CONDITIONS
- □ Diabetes
- □ Allergies _____
- □ Cancer
- □ Fibromyalgia
- □ Multiple Sclerosis
- □ Epilepsy
- □ Motor Vehicle Accident

OTHER HEALTH CARE
- □ Chiropractic
- □ Acupuncture
- □ Medical Doctor
- □ Physiotherapy
- □ Naturopathy
- □ Osteopathy
- □ Other: _____

INFORMED CONSENT FOR MASSAGE THERAPY

Massage Therapy is the manipulation of soft tissue and joints throughout the body. Your treatment may include advanced Massage Therapy techniques.

An accurate health history is important to ensure that it is safe for you to receive massage therapy treatment. Please ensure that this form is completed to the best of your knowledge and continue to inform your therapist of any changes to your health. All information provided will be held in strict confidence. Your written authorization is required for the release of any information. You will be required to review, revise and update your health history on a yearly basis as per the regulations of the *College of Massage Therapists of Ontario*.

CANCELLATION POLICY

Patients are required to provide 24 hours notice for any cancellation. That time has been reserved for you and we appreciate having adequate time to fill the spot. The clinic reserves the right to charge the full fee for a missed appointment or an appointment cancelled with less than 24 hours' notice.

PRIVACY POLICY

Please take the time to read and attached privacy policy. If you have any questions or concerns, please ask for clarification.

Patient Signature: _____

Date: _____

Therapist Signature: _____