Health History Form

The information below will assist in treating you safely. Feel free to ask any questions. Please note that all information will be kept confidential unless required by law. Your written permission will be required to release any information. Please update therapist of any future changes to the information provided.

Name: _____
Address (City/Postal): _____
Phone: _____
Email: _____
Date of Birth: _____
Have you received massage therapy before? Yes No

Ongoing medications & reason for taking:

_____ _____
_____ _____

Recent surgeries/injuries/hospitalizations & date:

_____ _____
_____ _____
_____ _____

Internal pins, wires, artificial joints, pace makers or special equipment?

_____

Allergies/sensitives (Include oils & fragrances)

_____

Special concerns or area of focus for massage?

_____
_____

THERAPIST NOTES

Initial HH: _____
Update: _____
Update: _____
Update: _____

Cardiovascular	**Respiratory**	**Head/Neck**
___ Blood pressure High Low ___ Congestive heart failure ___ Heart attack ___ Phlebitis/varicose veins ___ Stroke/CVA/Bells Palsy	___ Shortness of breath ___ COPD ___ Bronchitis ___ Asthma ___ Emphysema	___ Headaches ___ Migraines ___ Acute vision loss ___ Hearing loss ___ Epilepsy/Seizure
Musculoskeletal	**Neurological/Systemic Conditions**	**Skin Conditions & Infections**
___ Osteoporosis/Osteopenia ___ Arthritis Recent fractures or breaks _____ _____ Other (bursitis/tendinitis/sprains) _____ _____	___ Diabetes ___ Fibromyalgia ___ Pain/Nerve Syndromes (Neuropathy/TOS/Carpal/Sciatica) _____ _____ Other _____ _____	___ Psoriasis ___ Eczema ___ Cellulitis ___ Haemophilia Bruise easily? Yes No Other _____ _____ _____
Blood Infections ___ Hepatitis ___ TB ___ HIV **Other** Digestive Issues _____ Mental Illness _____ Other _____ Other _____	**Cancer** ____ Cancer Type/Location _____ Date DX _____ _____ _____ _____	**Women** ___ Gynaecological concerns Pregnant? Yes No Due: _____ Other _____ _____ _____

INFORMED CONSENT TO MASSAGE THERAPY TREATMENT

I understand that the massage therapist is providing massage therapy services within their scope of practice as directed by the College of Massage Therapists of Ontario.

I hereby give consent for my therapist to treat me with massage therapy for the above noted purposes including such assessments, examinations and techniques which may be recommended by my therapist. Massage therapy techniques may include and are not limited to modalities such as acupuncture, traditional general Swedish massage, reflexology, ultrasound, IFC & TENS, aromatherapy, kinesiology taping, cupping, fascial work, infrared lamp, hydro/cryotherapy, or mobility exercises and stretching.

I acknowledge that the therapist is not a physician and will not diagnose illness or disease or any other physical or mental disorder. I clearly understand that massage therapy or any clinical impression obtained through assessment or treatment is not a substitute for a medical examination. I acknowledge that no assurance or guarantee has been provided to me as to the results of the treatment. I acknowledge that with any treatment there can be risks and those risks have been explained to me and I assume those risks. If I experience any pain or discomfort during the session, I will immediately inform the therapist so that the pressure and/or strokes or chosen modality may be adjusted to my level of comfort or discontinued.

The therapist reserves the right to refuse to perform massage on anyone whom he/she deems to have a condition for which massage is contraindicated. In addition, I understand that any illicit or sexually suggestive remarks or advances will result in immediate termination of the session.

I acknowledge and understand that the therapist must be fully aware of my existing medical conditions. I have completed my medical history form as provided by my therapist and have disclosed to the therapist all of those medical conditions affecting me. It is my responsibility to keep the massage therapist updated on my medical history. The information I have provided is true and complete to the best of my knowledge.

I authorize my therapist to release or obtain information pertaining to my condition(s) and/or treatment to/from my other caregivers or third-party payers.

I have read the above noted consent and I have had the opportunity to question the contents and my therapy. By signing this form, I confirm my consent to treatment and intend this consent to cover the treatment discussed with me and such additional treatment as proposed by my therapist from time to time to deal with my physical conditions and concerns for which I have sought treatment. I understand that at any time I may withdraw my consent and treatment will be stopped.

Patient Name _____

Signature (Patient/Guardian) _____

Signature of Therapist _____ REG # _____

Date _____