

Date: _____ Updated: _____
 Updated: _____

HEALTH HISTORY FORM

An accurate health history is important to ensure that it is safe for you to receive a massage treatment. If your health status changes In the future, please let me know. All information gathered for this treatment is confidential unless allowed or required by law. Your written permission will be required to release any information.

PERSONAL INFORMATION

NAME: _____ HOME #: _____

ADDRESS: _____ CELL #: _____

POSTAL CODE: _____ EMAIL ADDRESS: _____

DATE OF BIRTH (D/M/Y): _____ CONSENT FOR CLINIC TO SEND EMAILS YES NO

OCCUPATION: _____ REFERRED BY: _____

HAVE YOU EVER EXPERIENCED MASSAGE THERAPY? ____ GENERAL HEALTH STATUS: POOR/FAIR/EXCELLENT

PLEASE **CIRCLE** ANY CONDITIONS YOU ARE EXPERIENCING, OR HAVE EXPERIENCED IN THE PAST:

RESPIRATORY	NEUROLOGICAL	DIGESTIVE	CARDIOVASCULAR	OTHER CONDITIONS
Chronic Cough	Loss of Sensation	Diarrhea	High Blood Pressure	Arthritis
Shortness of Breath	Numbness/Tingling	Constipation	Low Blood Pressure	Cancer
Bronchitis	Seizures	Crohn's Disease	Chronic Congestive Heart Failure	Diabetes: Onset _____
Asthma	Epilepsy	Colitis	Heart Attack	Headaches: _____
Emphysema	Sciatica	Irritable Bowel	Phlebitis/ Varicose Veins	Skin Conditions: _____
INFECTIONS:			Stroke/ CVA	Vision Problems
Hepatitis A,B,C,D			Heart Disease	Hearing Problems
Tuberculosis			Pacemaker/ Other Devices	Pregnancy: Due: _____
HIV/ AIDS				
Herpes				

Do you have any allergies? _____

Do you have any other medical conditions? (e.g. hemophilia, osteoporosis, fibromyalgia) Yes No

Please describe _____

Do you have any internal pins, wires, artificial joints or special equipment? Yes No

Please describe _____

Are you currently receiving treatment from another Health Care Professional? Yes No

If yes, for what? _____

Primary Care Physician : _____

Name of Chiropractor: _____

CURRENT MEDICATIONS

CONDITION IT TREATS

_____	_____
_____	_____
_____	_____
_____	_____

INJURIES - TYPE AND LOCATION ON BODY

DATE

_____	_____
_____	_____
_____	_____

SURGERY – PROCEDURE AND LOCATION ON BODY

DATE

_____	_____
_____	_____
_____	_____

What is the reason you're seeking massage? _____

INFORMED CONSENT

- ✓ You, the client, have the right to accept or refuse any treatment to your body
- ✓ You have the right to refuse, modify, or terminate any treatment, or any aspect of any treatment, at any time, regardless of prior consent
- ✓ Only those areas being treated will be undraped. Being fully draped or fully clothed during the treatment is also an option
- ✓ If the RMT feels that referral to another Health Care Provider is necessary, this will be communicated to the client and done so only with proper consent
- ✓ The RMT has the right to deny treatment if there is reasonable cause. This therapeutic relationship is based on mutual respect and commitment.
- ✓ **I have discussed the treatment and/or treatment plan with Amanda Craig, RMT. During this discussion, the benefits, risks, fees, side effects, areas to be treated, positioning and types of draping to be used have been explained to me. I fully understand and provide consent to treatment(s).**

PATIENT SIGNATURE _____ DATE _____