CONFIDENTIAL HEALTH HISTORY FORM

An accurate and current heath 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 us know. All information gathered for this treatment is confidential except as required by law to facilitate assessment or treatment. Only your written consent may allow the release of any information.

Initial Visit Date:_____
Updated:_____
Updated:_____
Updated:_____

NAME:_____

ADDRESS:_____**POSTAL CODE:**_____

PHONE (home):_____**(work):**_____**(cell):**_____

E-MAIL:_____

DATE OF BIRTH:_____ **AGE:**_____ **OCCUPATION:**_____

REASON FOR CONSULTING A MASSAGE THERAPIST?

__Stress Relief

__Prevention/Maintenance

__Problem Correction

Referred by:_____

How did you hear about us?_____

SPECIFIC AREAS OF CONCERN: (Please indicate **R**ight or **L**eft)

__Head	__Chest	__Abdomen
__Neck **R** or **L**	__Arm **R** or **L**	__Hand **R** or **L**
__Shoulders **R** or **L**	__Hip **R** or **L**	__Knee **R** or **L**
__Back__upper__mid__low	__Leg **R** or **L**	__Feet **R** or **L**

SYMPTOM DESCRIPTION:

__Dull Ache	__Tingling	__Cramping	__Twitching
__Sharp	__Stiffness	__Swelling	__Radiating
__Fiery	__Stabbing	__Numbness	__Weakness

OCCURRENCE OF SYMPTON:

Cause (& when began):_____

__Constant	__Periodic	__Chronic	__Acute
_____Frequency	_____Duration	_____Intensity	

AGGRAVATING FACTORS:_____

RELIEVING FACTORS:_____

LIST OF OPERATIONS, INJURIES, ILLNESSES AND DATES:

_____

_____

_____

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LIFE QUESTIONS: *Do you…? Please explain or describe.*

How would you describe your general health? _____

Drink water (glass)____per day Alcohol____per week Caffeine____per day

Smoke (pkg.)____per day Regular Activity____per week

PHYSICIANS NAME:_____**PHONE #:**_____

DATE OF LAST EXAMINATION:_____

CURRENT MEDICATIONS: vitamins / natural supplements and for what condition.

_____

_____

_____

PRESENT INVOLVEMENT IN OTHER HEALTH CARE: (why & how often)

Chiropractor:_____ Physiotherapist:_____

Massage Therapist:_____ Psychotherapist:_____

Other:_____

PLEASE INDICATE ANY CONDITIONS YOU MAY HAVE: (mark "**F**" if family history)

__Heart (heart disease)
__Stroke
__Chronic heart failure
__History of myocardial infraction
__History of cardio-vascular accident
__High __Low blood pressure
__Fainting __Dizziness
__Headaches __Migraines
__Vision __Hearing conditions
__Difficulty breathing
__Varicose veins __Phlebitis
__Bruise easily
__Spasm __Strain __Sprain

__Nausea
__Diarrhea __Constipation
__Pregnancy
__Insomnia
__Rashes __Open sores
__Cysts __Warts
__Asthma
__Bronchitis __Emphysema
__Chronic cough
__Diabetes (Type I or II)
__Arthritis
__Allergies:_____
__Other conditions: _____

__Herpes
__HIV
__Tuberculosis
__Hepatitis (A or B)
__Internal pins
__Internal Wires
__Artificial joints
__Pacemaker
__Implants
__Epilepsy
__Cancer:_____

FEES & CANCELLATION POLICY

All payments will be due upon services rendered. Massage is not a benefit of OHIP. However, many private Health Insurance Plans includes Massage Therapy coverage. A **24 hours notice** is required for cancellation of your appointment; otherwise you will be billed for 50% of the treatment fee.

INITIAL_____

CONSENT POLICY

Your comfort & trust in this clinic is very important. You are encouraged to actively participate by communication before, during and after therapy about any aspects of the treatment. The Massage Therapist respects your right to give informed and voluntary consent regarding care and treatment before providing treatment and that you have the right to make changes regardless of prior consent given.

****The above information is accurate and I understand and consent to: assessment, treatment and the policies listed.**

INITIAL_____