Health History form for Massage Therapy

The information requested below will assist us in treating you safely. If your health status changes, please let us know. Feel free to ask any question about the information being requested. Please note that all information provided below will be kept confidential unless allowed or required by law. Your written permission will be required to release any information outside this clinic.

Name:		Date of Birth (D/M/Y):	
Address:		City:	Postal Code:
Home Ph.	Cell Ph.	Business Ph. Ext.	
Email:	☐ Male ☐ Female	Ht:	Wt:
Occupation:	Employer:		
Primary Care Physician:	Address:		
Emergency Contact	Relationship:	Phone:	
Have you had prior Massage Therapy: ☐ Yes ☐ No Reason: ☐ Relaxation ☐ Medical Did a health care practitioner refer you for massage therapy ☐ Yes ☐ No If yes please provide their name and address if different from above			
What is your primary concern? Please include the location of any tissue or joint discomfort.			
☐ Work Related injury/accident (WSIB) Date of accident_____ Claim no:_____ ☐ Motor Vehicle accident (MVA) Date of accident:_____			
How did you hear about our office? ☐ Family Doctor ☐ Family/Friend ☐ Yellow pages ☐ Internet ☐ Other _____			

- **I understand that massage therapy involves the manipulation of soft tissues and joints of the body in order to develop, maintain, rehabilitate, improve physical function or relieve pain.**
- **I understand that during a massage treatment the massage therapist will, to the best of his/her ability, undrape only the area to be massaged, providing the draping, comfort, warmth, security and privacy as requested.**
- **I consent to a massage and I understand that I can change or terminate my treatment an any time.**
- **I also understand that I am responsible for any charges incurred in the course of my treatment.**
- **I understand that 24 hour notice is required to reschedule all future appointments or full charges will apply.**

Signature:_____ Date:_____

Please note this is a multi-disciplinary clinic. This is to confirm that I give my consent to allow the other health care workers at Richview Physiotherapy & Rehabilitation Centre Inc. the information in my file and administer treatment should it be required.

Patients Initials:_____

CURRENT MEDICATIONS ***(Includes topical, hormonals, supplements, remedies)***	**SPECIAL CONSIDERATIONS** ***(pls check any that apply)***
Drug Name **Used For** _____ _____ _____ _____ _____ _____	**☐ pacemaker ☐ artificial joint(s) ☐ rods, pins, wires ☐ chemo or drug port** **☐ artificial valve ☐ artificial limb(s) ☐ cane, walker wheelchair use** **☐ medication patch ☐ crutch ☐ breast implants ☐ other:** **Where? _____**

Systems Overview(Check any that apply)

RESPIRATORY
- ☐ Bronchitis/Chronic Cough
- ☐ Asthma
- ☐ Emphysema
- ☐ Shortness of Breath
- ☐ Other:_____

Is there a family history of any of the above? ☐ Yes ☐ No

CARDIOVASCULAR
- ☐ High Blood Pressure
- ☐ Low Blood Pressure
- ☐ Heart Attack/ Angina
- ☐ Heart Disease /CHF
- ☐ Phlebitis/Varicose Veins
- ☐ Poor Circulation/ Cold hands & feet
- ☐ Fainting/Dizziness
- ☐ Swelling of Ankles
- ☐Haemophilia
- ☐ Other: _____

Is there a family history of any of the above? ☐ Yes ☐ No

CENTRAL NERVOUS SYSTEM
- ☐ Epilepsy
- ☐ TIA/Stroke
- ☐ Multiple Sclerosis
- ☐ Paralysis
- ☐ Parkinsonism
- ☐ Fibromyalgia
- ☐ Nervousness
- ☐ Anxiety
- ☐ Epilepsy
- ☐ Depression
- ☐ Mental Illness
- ☐ Other:_____

INFECTIOUS CONDITIONS
- ☐ Hepatitis Type: _____
- ☐ HIV/AIDS
- ☐ Tuberculosis
- ☐Infectious Respiratory Condition
- ☐ Infectious Skin Condition
- ☐ Herpes
- ☐ Other:_____

SKIN
- ☐ Warts, Herpes
- ☐ Eczema
- ☐ Psoriasis
- ☐ Rashes
- ☐ Acne
- ☐ Bruise Easily
- ☐ Other:_____

LIFESTYLE
- ☐ Regular Exercise

Type?
- ☐ Difficulty Sleeping
- ☐ Drink Plenty of Water
- ☐ Good Eating Habits
- ☐ Fatigued

Energy Level ? Between 1-10

ALLERGIES
- ☐ Nuts
- ☐ Herbs
- ☐ Oil, Creams, Lotions
- ☐ Aromas, Airborne
- ☐ Latex
- ☐ Drug Allergy
- ☐ History of Anaphylaxis
- ☐ Other: _____

Systems Overview
(C-Current; P – Previous)

MUSCULOSKELETAL
- ☐ C ☐ P Jaw Problem
- ☐ C ☐ P Neck Problem
- ☐ C ☐ P Shoulder Problem
- ☐ C ☐ P Arm Problem
- ☐ C ☐ P Wrist Problem
- ☐ C ☐ P Hand Problem
- ☐ C ☐ P Upper Back Problem
- ☐ C ☐ P Mid Back Problem
- ☐ C ☐ P Low Back Problem
- ☐ C ☐ P Hip Problem
- ☐ C ☐ P Leg Problem
- ☐ C ☐ P Knee Problem
- ☐ C ☐ P Ankle Problem
- ☐ C ☐ P Foot Problem
- ☐ C ☐ P Bursitis

Loss or Altered Sensation
Where? _____

☐ Arthritis/ Osteoporosis
Type? _____
Where? _____
Do you have a family history of arthritis?
☐ Yes ☐ No

☐ History of Headaches or Migraines
Type? _____ Frequency? _____

SURGERIES

	Year	Type
1.		
2.		
3.		

Current Complications?

INJURIES

	Year	Type
1.		
2.		
3.		

Current Complications?

Systems Overview
(C-Current; P – Previous)

☐ ***Diabetes***
Type? _____
Year Diagnosed? _____
Current Complications?_____

☐ ***Cancer***
Type? _____
Year Diagnosed? _____
- ☐ C ☐ P Chemotherapy
- ☐ C ☐ P Radiation

Current Complications?

EYES/EARS/NOSE/THROAT
- ☐ Visual Impairment
- ☐ Eye glasses/contacts
- ☐ Hearing Impairment
- ☐ Hearing aid
- ☐ Ear Aches
- ☐ Sore Throat
- ☐ Dental Problems
- ☐ Stuffed nose/ Sinus
- ☐ Swollen Glands

DIGESTION/URINATION
- ☐ Constipation
- ☐ Diarrhea
- ☐ Irritable Bowel Syndrome
- ☐ Crohn's Disease
- ☐ Kidney Disease
- ☐ Recurrent Infection
- ☐ Prostate Problem
- ☐ Poor/Excessive Appetite
- ☐ Excessive Thirst
- ☐ Gas/Bloating
- ☐ Nausea/Vomiting
- ☐ Ulcer
- ☐ Abdominal Cramps
- ☐ Gallbladder Problems
- ☐ Liver Problems
- ☐ Other: _____

WOMEN
Pregnant ? Due:_____
- ☐ High Risk Pregnancy
- ☐ Menstruation Issues
- ☐ Menopause Issues
- ☐ Breast Pain
- ☐ Breastfeeding
- ☐ Endometriosis
- ☐ Other?_____

OTHER HEALTH CARE
- ☐ C ☐ P Physiotherapy
- ☐ C ☐ P Chiropractic
- ☐ C ☐ P Naturopathy
- ☐ C ☐ P Medical Specialist
- ☐ C ☐ P Other: _____

Overall how is your general Health?