REGISTERED MASSAGE THERAPIST
Professional Hands You Can Trust

Massage Therapy Health History Form

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The information requested below will assist me in treating you safely and effectively. Please note that all information provided below will be kept confidentially unless allowed or requested by law (your written permission will be required). Any questions regarding your visit, please feel free to ask!

Name:_____ Phone: (H) _____ (W) _____

E-mail: _____ Mobile: _____ Today's Date: _____

Address: _____ City: _____ Postal Code _____

Occupation: _____ Date of Birth: _____

Primary Care Physician – Name & Address: _____

Where did you hear about me? _____ Have you had a massage before? ❑ YES ❑ NO

What brings you in for a massage? _____

Overall, how is your general health? _____

Please indicate conditions you are experiencing or have experienced:

CARDIOVASCULAR

Current/Previous

- ❑ ❑ High Blood Pressure
- ❑ ❑ Low Blood Pressure
- ❑ ❑ Chronic Congestive Heart Failure
- ❑ ❑ Heart Attack
- ❑ ❑ Varicose Veins
- ❑ ❑ Stroke/ CVA
- ❑ ❑ Pacemaker or Similar Device
- ❑ ❑ Poor Circulation
- ❑ ❑ Heart Disease

RESPIRATORY

Current/Previous

- ❑ ❑ Chronic Cough
- ❑ ❑ Shortness of Breath
- ❑ ❑ Bronchitis
- ❑ ❑ Asthma
- ❑ ❑ Emphysema
- ❑ ❑ Problems Breathing

HEAD/ NECK

Current/Previous

- ❑ ❑ Headaches: Type: _____
- ❑ ❑ Vision Problems
- ❑ ❑ Earaches
- ❑ ❑ Vertigo/ Dizziness
- ❑ ❑ TMJ Dysfunction

NOTES:

WOMEN

Current/ Previous

- ❑ ❑ Menstrual Problems
- ❑ ❑ Gynecological Conditions: What? _____

Pregnant? ❑ Yes ❑ No

Due Date: _____

Number of Children: _____

INFECTIONS

Current/Previous

- ❑ ❑ Hepatitis: _____
- ❑ ❑ Herpes
- ❑ ❑ Skin Conditions
- ❑ ❑ TB
- ❑ ❑ HIV/ AIDS

OTHER HEALTH CARE

Current/ Previous

- ❑ ❑ Massage Therapy
- ❑ ❑ Chiropractic
- ❑ ❑ Physiotherapy
- ❑ ❑ Osteopathy
- ❑ ❑ Naturopath
- ❑ ❑ Psychotherapy

CURRENT MEDICATIONS

Medication: _____

Condition: _____

Medication: _____

Condition: _____

OTHER CONDITIONS

Current/ Previous

- ❑ ❑ Liver
- ❑ ❑ Gall Bladder
- ❑ ❑ Kidney/ Bladder
- ❑ ❑ Diabetes – Onset: _____
- ❑ ❑ Insomnia
- ❑ ❑ Cancer: Where? _____
- ❑ ❑ Loss of Sensation Where? _____
- ❑ ❑ Arthritis Where? _____
- ❑ ❑ Internal wires, pins, Artificial joints? Where? _____

PREVIOUS INJURIES/ SURGERIES

Nature: _____

Date: _____

Nature: _____

Date: _____

Nature: _____

Date: _____

Please turn over and fill out back of form please…

Massage Therapy Health History Form

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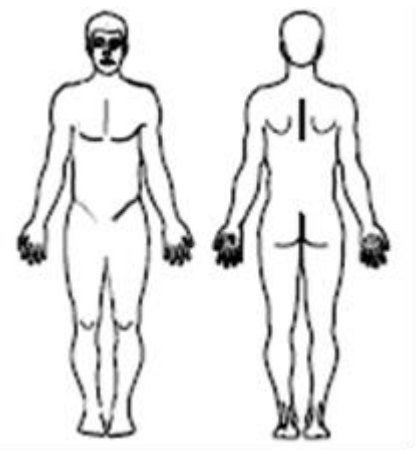
Please mark an "X" on the picture where you feel discomfort



Please check off where you feel discomfort.

❑ Neck	❑ Upper Back	❑ Lower Back	❑ Mid Back
❑ Arms	❑ Hands	❑ Hips	❑ Thighs
❑ Lower Legs	❑ Knees	❑ Ankles	❑ Feet
❑ Chest	❑ Abdomen	❑ Head	❑ Gluteals/ Buttocks

❑ Other: _____

How long have you experienced it? _____

What tends to aggravate your pain? _____

What tends to relieve your pain? _____

Informed Consent

I understand that the purpose of massage therapy is to restore and maintain the integrity of the musculo-skeletal system. I understand that massage therapy is a hands-on health care discipline that will require the therapist to place his/her hands on those areas of the body that are involved in the cause of my symptoms. I am aware that my Therapist is a Registered Health Care Professional and has the right to discontinue the treatment at their discretion.

I understand that I have complete control of my own treatment and the right to change/alter, or discontinue the treatment at any time should I feel uncomfortable.

I understand that massage therapists do not diagnose illnesses, disease, or any physical or mental disorders; nor do they prescribe medical treatment, pharmaceuticals, or perform spinal manipulations.

I acknowledge that massage is not a substitute for medical examination or diagnosis, and that it is recommended that I see a primary healthcare provider for that service.

I further understand that in the practice of massage therapy there is potential for mild side effects, including but not limited to, muscle soreness/point tenderness in areas worked (lasting up to 24-48 hours), mild bruising, headache, and possibly feeling lightheaded. Following the treatment feelings of fatigue are common. Cold packs on achy areas (10min on, 10min off) will help minimize any discomfort. Please feel free to call or email me at any time if you have any questions or concerns.

Fee is due at the time of treatment; cash, cheques, interac, visa, mastercard are accepted.
Without 24 hours notice you will be billed for your missed appointment.

I _____ have read and acknowledge all the above information and give my consent for massage treatment/ assessment.

(please print name)

Signature: _____ **Date:** _____

(If patient is a minor- signature of parent/ guardian)