Back in Balance
A centre for wellbeing

Health History Form for Registered Massage Therapy

The information request below will assist us in treating you safely. Feel free to ask any questions 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.

Name: _____ Date: _____
Address: _____
Postal Code: _____ Date of Birth: _____ □Male □Female □ Non-Binary
Home Tel no: _____ Work Tel no: _____ ___ Cell no: _____
Email address: _____ Occupation: _____
Please indicate your reminder preference: □ ***email*** □ ***phone call*** □ ***text*** ***If text, indicate cell carrier:*** _____
Would you like to subscribe to our monthly newsletter for stretches, chiropractic tips, and recipes? □ Yes □ No
In case of emergency contact_____ Relationship_____ contact tel. ( )_____
Will you be making a claim for a Motor Vehicle Accident or WSIB? □ Yes □ No
For children under the age of 18: Name of Parent #1: _____ Name of Parent #2: _____
Have you received massage therapy before? □ Yes □ No
Did a health care practitioner refer you for massage therapy? □ Yes □ No
If yes, please provide their name and address _____
Primary Care Physician's name and address_____
Whom may we thank for referring you to our centre? _____

Please indicate below any of the conditions or symptoms you have, or have experienced in the past. If there is any family history of these conditions, please mark with an "F".

Cardiovascular
□ High blood pressure
□ Low blood pressure
□ Chronic congestive heart failure
□ Heart attack/ MI
□ Phlebitis/varicose veins
□ Stroke/ CVA
□ Pacemaker or similar device
□ Heart disease

Respiratory
□ Chronic cough
□ Shortness of breath
□ Bronchitis
□ Asthma
□ Emphysema

Infections
□ Hepatitis □ Skin conditions
□ Infectious respiratory conditions
□ HIV □ Herpes

Other Conditions
□ Loss of sensation and where:
_____
□ Diabetes: onset: _____
□ Allergies/hypersensitivity: type of allergy and type of reaction:_____
_____
□ Epilepsy
□ Cancer: type and date of onset:
_____

□ Skin conditions:_____
_____
□ Arthritis: _____
_____

Head/Neck
□ History of headaches
□ History of migraines
□ Vision problems /loss
□ Ear problems/loss

Women
□ Are you pregnant? Due date:
_____
□ Gynaecological conditions.
Explain:_____

Overall, how is your general health? _____
_____
_____
Current medication(s): _____
Condition(s) it treats: _____
Please list any surgery (s). Date and type: _____
Please list any injuries /accidents: Date and type: _____
Do you have any other medical conditions? (e.g. digestive, haemophilia, osteoporosis, mental illness) □ Yes □ No
If yes, please specify: _____

Do you have any internal pins, wires, artificial joints or special equipment? □ Yes □ No
If yes, please specify type and location: _____
Do you have any tissue or joint discomfort? □ Yes □ No If yes, specify where: _____
_____

Are you currently receiving treatment from another health care professional? □ Yes □ No
If yes, please specify type of treatment _____
What is the reason you are seeking massage therapy? _____

Massage Therapist Notes

Date of Initial Health History: _____
Update 1 _____ Update 2 _____ Update 3 _____Update 4 _____