

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

Preferred Pronouns: _____

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? ☐ 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

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? _____

Please initial to confirm that you have read our office fees and policies: _____

Massage Therapist Notes

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

Limitations of activities of daily living:

Treatment plan discussed with Client:

Yes / No

Clients Goal / Treatment Goal:

Received informed consent for treatment

Type / Focus of treatment:

plan: Yes / No

Frequency: _____ Duration: _____

Areas to be treated:

back

arm L R

chest

neck

leg L R

breast

shoulders

gluteus

other (list)

face

abdominals

Assessments Performed:

Anticipated Progression of Responses:

Results of Assessments:

Remedial exercises/ Hydrotherapy
recommended:

Reassessment schedule:

Contraindications / Risk

Referrals:



