MASSAGE THERAPY HEALTH HISTORY FORM

Please complete this form to the best of your knowledge and PRINT legibly. All information is confidential and will not be released without your written authorization.

Last Name: _____ First Name: _____ Male □ Female□ Date of Birth:_____

Address: _____ City:_____ Postal Code: _____

Emergency Contact (name): _____ Phone # : _____

Home Telephone #:( )_____Work Telephone #:( )_____ Cell # ( ): _____

Employer: _____ Occupation:_____

Family Physician: _____ Address:_____ Telephone #:_____

Who referred you?:_____ Have you ever had massage therapy?:_____

Primary Concern:_____ General Health Status:_____

Medications: _____ Reason for use: _____

_____ Reason for use: _____

_____ Reason for use: _____

_____ Reason for use: _____

PRESENT INVOLVMENT IN ANY OTHER HEALTH CARE

☐ Chiropractic ☐ Physiotherapy ☐ Alternative therapies ☐ Other:_____

SOFT TISSUE AND JOINT (Problem Areas)

☐ Shoulder ☐ Hip ☐ Muscle weakness
☐ Elbow ☐ Knee ☐ Muscle soreness
☐ Hand ☐ Ankle ☐ Other:_____
☐ Spine ☐ Feet ☐ Other:_____

LIFE STYLE (Regular Use)

☐ Exercise ☐Other:_____
☐ Alcohol/Drugs
☐ Coffee/Tea
☐ Cigarettes

HEALTH HISTORY – Please indicate conditions you are experiencing or have experienced.

☐ Hemophilia ☐ Emphysema ☐ Allergies ☐ Pelvic Inflammatory Disease
☐ C.V.A/ Stroke ☐ Asthma ☐ Local Skin Irritation ☐ Pregnancy
☐ Bronchitis ☐ Anaphylactic Shock ☐ Headache/Migraine ☐ Myocardial Infarction
☐ Hypertension ☐ Chronic Cough ☐ Pins/Plates/Needles ☐ Chronic Abdominal Discomfort
☐ Low Blood Pressure ☐ Breathing Difficulty ☐ Artificial joint ☐ Prolonged Constipation
☐ C.C.H.F. ☐ Tuberculosis ☐ Diabetes ☐ Cosmetic Implants
☐ Epilepsy ☐ Hearing/Vision Loss ☐ Pace Maker ☐ General Circulatory Disorder
☐ Varicose Veins ☐ Multiple Sclerosis ☐ HIV/Aids ☐ Bruise easily

☐ Phlebitis	☐ Loss of Sensation	☐ Cancer	☐ Family History of Arthritis
☐ Dizziness	☐ Arthritis	☐ Hepatitis	☐ Other:_____
☐ Chest Pain	☐ Osteoporosis	☐ Endometriosis	☐ Other:_____

PAST SURGERIES OR INJURIES:	**DATE**	**TREATMENT RECEIVED**
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

ADDITIONAL COMMENTS/CONCERNS:

_____

_____

_____

_____

_____

CONSENT:

I, _____ consent to massage therapy treatments and/or acupuncture treatments. Also, I verify that the information given on this form is true and accurately reflects my past and present health status. If my health status changes in the future, I will inform you immediately. I also understand that cancellation of any appointments should be made 24 hours before the scheduled appointment.. Failure to notify us within this time frame will incur a fee of 50% of the treatment costs.

Physiotherapy Active Rehab is the Health Information Custodian for your records and is responsible for protection, collection, use and disclosure of your personal information according to privacy rules set by the Personal Health Information Act (PHIPA) and by the Personal Information Protection and Electronic Document Act (PIPEDA).

_____ _____

Signature Date:

_____

Print Name