RMT Health History Form

The information below will assist us in treating you safely. Please feel free to ask questions about information being requested. Please note that all information provided below will be kept confidential unless allowed or required by law. Your permission will be required to release any information, and you have the right to give, withhold or withdraw your consent to collect, use or disclose any personal health information at any time.

PATIENT INFORMATION	
Name:	Date of Birth: (dd/mm/yyyy)
Address:	
City	Province: Postal Code:
Phone number:	Work Phone:
Cell Phone:	Email:
Preferred Method of Contact:	Gender: Pronouns:
Occupation:	
Accessibility Needs:	
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:	
Family physician name and address:	
Have you received treatment from another health care professional in the past year? __ Yes __No If yes, please provide type of treatment: (chiropractic, physiotherapy, etc..):	
Emergency Contact Name: Phone:	

GENERAL HEALTH INFORMATION
Primary reason(s) for seeking massage therapy:
Do you have any allergies: __ Yes __No If yes, list your allergies and indicate if they require an Epi-pen:
Please list any recent/current injuries, and dates of occurrence:
Were these injuries sustained as a result of a motor vehicle accident? __ Yes __No
Were these injuries sustained at work? __ Yes __ No
Please list all surgeries including any internal pins, wires or artificial joints and dates:
List any health issues you have related to the following categories that may impact your massage therapy care. Muscle, joint or bone issues (arthritis, muscle strain etc.): Heart or circulation concerns (high blood pressure etc.): Lung or breathing issues (asthma etc.): Neurological symptoms or conditions (dizziness, numbness, epilepsy/seizures, stroke, MS etc.): Skin conditions that may impact your reaction to treatment (bruise easily, eczema, rashes etc.): Gynecological concerns (pregnancy, menstrual concerns, menopause etc.): Other conditions that may impact your massage therapy care:

Are you taking any medications or substances that may affect your sensitivity, healing or ability to receive massage? __ Yes __ No
If Yes, please list medications:

Are you experiencing any of the following symptoms: chronic pain, fatigue, tension, swelling, numbness, or inflammation? __ Yes __ No
If yes, please describe:

OPTIONAL HEALTH DISCLOSURES

Cancer Treatment History:
Have you been diagnosed with cancer or received or are currently receiving cancer treatment?
__Yes __ No
If Yes, please describe any symptoms this may be causing you, as massage therapy can help address many of the symptoms related to cancer and cancer treatments:

Physical Symptoms Related to Mental Health (stress, anxiety, depression etc.)
Mental health concerns can contribute to physical symptoms such as musculoskeletal pain, and many of these physical symptoms can be addresses by massage therapy. Are you experiencing physical symptoms such as fatigue, tension, or sleep disturbances that may relate to mental health?
__ Yes __ No
If Yes, please describe:

I have read the above information and have stated all my previous and current medical conditions. I will update the Registered Massage Therapist regarding any updates in my condition as soon as possible.

In order to provide treatment, this clinic must collect personal health information. I understand that all information that I have provided will be kept confidential unless allowed or required by law. I understand that I will be asked for written authorization before this information can be released. Our clinic, when contacted by your extended health care insurance, will confirm your treatments.

Signature: _____ Print Name:_____
Date: _____

MASSAGE THERAPY OFFICE POLICIES

1. If you need to cancel an appointment you must notify the office at least 24 hrs before your scheduled appointment (during business hours). A charge of the **full appointment** fee will be applied for less than 24 hrs notice and for missed appointments.

2. All financial accounts must remain current.

3. Immediate family members are automatically linked in our computer system, for billing purposes, unless requested otherwise.

4. We will confirm appointment attendance with Extended Health Insurance Companies.

5. It may be necessary for this office to communicate by phone to any of the numbers you have provided to us on the Health History Form. If you choose not to have us call, please let us know.

Print Name:_____ Date:_____

Signature:_____