MASSAGE HEALTH HISTORY FORM

WELCOME TO
BODY + SPINE CHIROPRACTIC AND NATURAL THERAPIES CLINIC

An accurate health history is important to ensure that it is safe for you to receive a massage treatment. If your health status changes in the future, please let us know. All information gathered for this treatment is confidential except as required or allowed by law or except to facilitate diagnosis (assessment) or treatment. You will be asked to provide written authorization for release of any information.

Name ________________________________ **Date** ______________________

Address ____

City, Province ______________________________ **Postal Code** ________________

Home Tel ______________________ **Bus. Tel** ____________________ **Cell** ______________________

E mail ____

Date of Birth (D/M/Y) __________________ **How did you hear about us?**________________________

Occupation ____

WHAT IS YOUR PRIMARY COMPLAINT?

____

____

Please indicate conditions that you are experiencing or have experienced

- ☐ emphysema
- ☐ chronic cough
- ☐ shortness of breath
- ☐ bronchitis
- ☐ asthma

- ☐ high blood pressure
- ☐ low blood pressure
- ☐ CCHF
- ☐ heart attack
- ☐ phlebitis
- ☐ stroke/CVA
- ☐ pacemaker or similar device

- ☐ arthritis
- ☐ loss of sensation
- ☐ diabetes (onset_______)
- ☐ allergies (ie. anaphylaxis)
- ☐ cancer
- ☐ epilepsy

- ☐ vision problems
- ☐ ear problems
- ☐ hearing loss

- ☐ hepatitis
- ☐ TB
- ☐ HIV

- ☐ neck
- ☐ shoulders
- ☐ upper back
- ☐ mid back
- ☐ low back
- ☐ arms
- ☐ legs
- ☐ knees

- ☐ skin conditions

- ☐ pregnant
  due ___________

Other medical conditions ____

Current medications ____

Condition it treats ____

Surgery ____

Injuries ____

Of Special Note (internal pins, wires, artificial joints) _________________________________

Primary Care Physician ____

Present involvement in other health care ____

Please specify any other symptoms or medical information that you feel would be relevant

____

Has anything aggravated your primary condition of concern? ________________________

____

Has anything relieved your primary condition of concern? __________________________

____

At any time before or during the treatment process, please feel free to ask your therapist any questions or concerns you may have regarding your treatment.

I ____________________________ **of my own free will consent to be treated for the above stated areas of concern**

I acknowledge that the therapist will/has provided me with such information as is pertinent to treatment for my above listed complaints.

Alternative courses of treatment, where applicable and relevant, have been explained to me, as well as the possible risks and side effects of the proposed treatment plan.

I fully understand the consequences of having treatment/not having treatment.
I understand that I may stop the treatment at any time before or during the treatment process.

CANCELLATION POLICY: We require 24 hours notice of appointment cancellation, otherwise full treatment fee may be charged to you by your therapist. Thank you.

Print Name ____

Signature ____

Date ____________________________

This form is recognized by the College of Massage Therapists of Ontario to contain the elements necessary to ensure compliance with the Standards of Practice

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