MASSAGE THERAPY HEALTH HISTORY

Date:____________________

Update 1____________________
Update 2____________________

Name: ____
First Initial Last

Address: ____
Street Apt. City Province Postal Code

Phone: (____)______________ Cell: (____)_____________ Bus. phone: (____)_____________x_______________

E-mail ____

D.o.B: (dd/mm/yyyy)______________ Age:_______ Previous Massage Experience: □Y □ N

Type of Work: _________________________________

Emergency contact: _________________________________ Phone: ____________________________________

Were you referred for massage therapy? □ Y □ N if yes, by whom: ___________________________________

What is your chief complaint?: ____

Are you seeing any other practitioner currently for this condition: □Y □ N Name:________________________

What is your general health status? ____

Physician's Name: ____ Phone: __________________________

Address:____

Current Medications____

Please check the conditions that you are currently experiencing, or have experienced often in the past.

Head/Neck
□ headaches
type: ________________
□ vision problems
□ vision loss
□ ear problems/loss

Cardiovascular
□ high blood pressure
□ low blood pressure
□ poor circulation
□ heart disease
□ phlebitis/varicose veins
□ stroke/CVA
□ pacemaker or similar device
□ chronic congestive heart failure
□ heart attack
Family history of any of the above
□ Y □ N

Skin
□ skin conditions
type:_________________
□ plantar warts
□ bruise easily

Respiratory □ chronic cough
□ shortness of breath
□ smoking
□ bronchitis
□ emphysema
□ asthma
Family history of any of the above
□ Y □ N

Infections
□ hepatitis
□ TB
□ HIV, AIDS
□ herpes
□ Other: _____________

Women
□ menstrual problems □ painful
□ gynecological conditions
what______________________
□ Pregnant: due date: ________
□ Children: number _________
□ caesarian section

Injury date:____________________
Type____________________________
____

Surgery date:___________________
type______________________________
____

Other Conditions
□ difficult digestion
□ constipation
□ liver
□ epilepsy
□ gall bladder _________
□ kidney ______________
□ bladder ______________
□ diabetes- onset ________
□ sinus
□ allergies/hypersensitivity
□ insomnia
□ cancer where_____________
□ arthritis Dr. diagnosed? □Y □ N
affected areas_______________
Family history of arthritis
□ Y □ N

Other medical conditions
____

Internal pins, wires, artificial joints or special equipment □ Y □ N
What_________________________

INFORMED CONSENT TO MASSAGE THERAPY ASSESSMENT AND TREATMENT

I have received information about the proposed physical assessment and have been informed about the nature of the massage therapy treatment. I have been informed and understand the benefits, risks, side effects, contraindications (if present), alternatives courses of treatment and consequences of not having the treatment. I understand that it is my right to stop or modify the treatment at any time and that the massage therapist expects my input regarding the comfort of pressure throughout the treatment. The therapist has given me instruction on dressing/undressing procedures as well as instruction on positioning and covering during the treatment, hydrotherapy applications and remedial exercise programs. I am fully aware of the cost of the treatment and duration of both the treatment and assessment.

Massage Treatment	Cost
30 minutes	$60.00
45 minutes	$80.00
60 minutes	$100.00
90 minutes	$135.00
120 minutes	$190.00

All information in my file will be kept confidential, although the file will be shared among the treating therapists in this facility. The sharing of the file will improve the flow of information among the professionals to ensure the utmost quality of care.

I understand that written authorization will be obtained prior to the release of any information, except when required by a court of law.

I understand that my treatment may change from time to time, and necessary functional ability testing may be performed at my health professional discretion. I also understand that results are not guaranteed.

I have read the above consent and have had the opportunity to ask questions regarding its content. By signing below I agree to the proposed physical testing and massage therapy protocol presented by the registered massage therapist. I intend this consent to cover the entire course of treatment for my present condition and any future condition(s) for which I seek treatment.

Please note:

Time of treatment includes assessment and dressing/undressing.

Please, be in-time for your appointment. If you are late the time of your treatment may be decreased but you will be charged in full for scheduled appointment.

If you need to cancel your appointment please give us 24 hour notice. Otherwise you may be charged for missed appointment

______________________________	______________________________
RMT Name (please print)	Client/Guardian (please print)
______________________________	______________________________
RMT Signature	Client Signature

Date:______________________________