Date:

MassageWorks! Inc.

CONFIDENTIAL HEALTH HISTORY

An accurate health history is important to ensure that it is safe for you to receive 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 to facilitate diagnosis or treatment. You will be asked to provide written authorization before the release of any information.

NAME: First_____ Last _____File # ☐
(office use only)

Address _____City _____ Postal Code_____-_____

PHONE: Home _____ Work _____ Ext_____ Cell_____

Email Address _____

Date of Birth: _____/_____/_____ Emerg.Contact/Spouse:_____
Day Month Year (if applicable)

R / L Handed: ___ Occupation: _____ Hobbies: _____

General Health Status?_____

Your primary complaint?_____

Primary Care Physician: _____Address: _____

Present involvement in other health care? _____

How did you choose MassageWorks! ❑Referred by _____

❑Advertisement_____

REASONS FOR RECEIVING THERAPY:

- ❑ **Motor Vehicle Accident** (past or present) _____
- ❑ **Injury** please specify _____
- ❑ **Athletics** _____
- ❑ **Stress / Relaxation**
- ❑ **Gift Certificate**

Have you previously received Massage / Manual Therapy? ❑ Yes ❑ No

For what condition?_____ With Whom?_____

For Future Appointments: Please understand that by reserving an appointment time you have agreed to pay for that time. If you must cancel your appointment, a minimum notice of 24 hours is required or the full treatment charge will apply whether or not you choose to attend your scheduled appointment. **Signature:**

HEALTH HISTORY

Please check ☑ conditions you are experiencing or have experienced in the past.

SKIN
- ❑ rashes/bruise easily
- ❑ infectious skin conditions
- ❑ contagious skin conditions _____
- ❑ Other: _____

MUSCLES/JOINTS

Indicate Left or Right where appropriate to discomfort.
- ❑ upper back
- ❑ mid back
- ❑ lower back
- ❑ neck
- ❑ shoulders
- ❑ elbows
- ❑ arm
- ❑ wrist
- ❑ hand
- ❑ hip
- ❑ leg
- ❑ knee
- ❑ ankle
- ❑ foot
- ❑ weakness or loss of strength
- ❑ clumsiness
- ❑ osteoarthritis
- ❑ rheumatoid arthritis
- ❑ other arthritis: _____
- ❑ family history of arthritis
- ❑ osteoporosis
- ❑ tendonitis Location _____
- ❑ strains _____
- ❑ joint sprain/dislocation location _____
- ❑ artificial joints/pins/wires/screws location _____

RESPIRATORY
- ❑ asthma
- ❑ bronchitis
- ❑ chronic cough
- ❑ difficult breathing
- ❑ emphysema
- ❑ shortness of breath
- ❑ smoking
- ❑ other: _____

CARDIOVASCULAR
- ❑ high/low blood pressure: Bp:_____
- ❑ bleeding disorder
- ❑ hemophilia
- ❑ arteriosclerosis
- ❑ heart attack
- ❑ heart disease
- ❑ angina
- ❑ stroke/cerebro-vascular accident
- ❑ pacemaker
- ❑ varicose veins
- ❑ phlebitis
- ❑ poor circulation
- ❑ other: _____

HEAD/NECK
- ❑ visual impairment _____
- ❑ hearing impairment _____
- ❑ speech impairment _____
- ❑ sinus problems
- ❑ jaw pain (TMJ pain)
- ❑ headache/migraine _____

GI CONDITIONS
- ❑ constipation
- ❑ diarrhea
- ❑ irritable bowel: _____
- ❑ hiatus hernia
- ❑ ulcers

OTHER CONDITIONS
- ❑ allergies _____
- ❑ cancer
- ❑ diabetes
- ❑ fainting
- ❑ fever
- ❑ insomnia
- ❑ numbness/tingling: where?_____
- ❑ seizures

INFECTIOUS CONDITIONS
- ❑ Herpes / STD's
- ❑ hepatitis:_____
- ❑ HIV / AIDS
- ❑ TB

FRACTURE: ❑ Yes ❑ No
location _____

SURGERY: ❑ Yes ❑ No
for: _____

MOTOR VEHICLE ACCIDENT: ❑ Yes ❑ No
Other Symptoms:_____
_____
_____
_____

WOMEN
- ❑ pregnant **due:** _____
- number of children:_____
- ❑ menstrual difficulties
- ❑ gynecological conditions: _____

Medications PLEASE LIST ALL MEDICATIONS, NATURAL REMEDIES, SUPPLEMENTS etc…

_____

_____

_____

MassageWorks! Inc.

CONSENT FORM

I understand that Massage Therapy involves the manipulation of soft tissues and joints of the body in order to develop, maintain, rehabilitate, improve physical function or relieve pain. I understand that during a massage treatment the massage therapist will, to the best of his/her ability, undrape only the area to be massaged, providing the draping, comfort, warmth, security and privacy as requested.

The College of Massage Therapists of Ontario requires that patients be aware of the following regarding their treatment programs: Informed Consent will be assured during all aspects of assessment and treatment. As a patient in the Ontario health care system you may terminate any assessment or treatment at any time.

By signing the consent section of this Patient Consent Form, you have agreed that you have given your informed consent to the collection, use and or disclosure of your personal information for the purposes that are listed in the Privacy Policy. If a new purpose arises for the use and / or disclosure of your personal information, we will seek your approval in advance.

Your information may be accessed by regulatory authorities under the terms of the Regulated Health Professions Act (RHPA) or by the Ontario Massage Therapy Association or College of Massage Therapists of Ontario for the defense of a legal issue.

Our office will not under any conditions supply your insurer or any other party with your confidential medical history, unless you have provided a signed release form. In the event this kind of a request is made, we will forward the information directly to you for review, and for your specific consent.

When unusual requests are received, we will contact you for permission to release such information. We may also advise you if such a release is inappropriate.

You may withdraw your consent for use or disclosure of your personal information, and we will explain the ramifications of that decision, and the process.

Patient Consent (please read carefully)

I have reviewed the above information that explains how your office will use my personal information, and the steps your office is taking to protect my information.

I know that your office has a Privacy Code, and I can ask to see the Code at any time.

I agree that MassageWorks! may collect, use and disclose personal information about me as set out above in the information about the office's privacy policies.

I accept that I am ultimately responsible for the payment of all fees for any treatments, services, reports, etc. incurred in the course of treatment. I also understand that I will be charged in full for appointments missed without advance notice of at least 24 hours.

Date: _____ Patient Signature: _____

(or parent/guardian if patient is under the age of 16)

Therapist Signature: _____