Health History

The information request below will assist us in treating you safely. Feel free to ask any questions about the information being requested. Please note that all information provided below will be kept confidentially unless allowed or required by law. Your written permission will be required to release any information.	
Name:	**Date of Birth:**
Address:	
Home/mobile #:	**Email:**
Have you received massage before? (Y/N)	**Emergency Contact (Name & Number):**
Referred by health practitioner/physician? If yes, please provide <u>name</u> and <u>address</u>	

Primary complaint:	
Current medications and condition it treats:	
Injuries & date:	
Any internal pins, wires, artificial joints?	**Surgery (nature & date):**
MVA (Y/N) - if <u>YES</u>, where were you hit?	**Receiving treatment from another health care practitioner? If <u>YES</u>, for what?**

Please indicate conditions you are experiencing or have experienced

Cardiovascular	
☐ High Blood Pressure	☐ Low Blood Pressure
☐ Chronic Congestive Heart Failure	☐ Heart Attack
☐ Phlebitis/ Varicose Veins	☐ Stroke/CVA
☐ Pacemaker	Other:

Respiratory	
☐ Chronic Cough	☐ Shortness of Breath
☐ Asthma	☐ Bronchitis
☐ Emphysema	Other:

Infections	
☐ Hepatitis	☐ Skin conditions
☐ HIV	☐ TB
☐ Herpes	Other:

Head/Neck	
☐ History of Headaches	☐ History of Migraines
☐ Vision Problems	☐ Vision Loss
☐ Ear Problems	☐ Hearing Loss

Other Conditions	
☐ Diabetes (onset)	☐ Allergies (to what)
☐ Loss of sensation (where)	☐ Epilepsy (triggers)
☐ Cancer (type)	☐ Arthritis (where)
Any other medical conditions (ie. Digestive, haemophilia, osteoporosis, mental illness)	

Pleasure ensure you read the following information in its entirety

I have read the above information and have stated all my previous and current medical conditions. I will update the Registered Massage Therapist (RMT) 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 provide will be kept confidential unless required by law. I understand that I will be asked for written authorization before this information can be released.

I understand the 24-hour cancellation policy and agree to pay the missed appointment fee if I cancel within the 24-hour period preceding my appointment time. I understand that I am responsible to pay for the time reserved with the RMT, regardless of the time I arrive and am ready for my appointment. I understand that this time will include intake, assessment, treatment, self-care recommendations, charting and administration. I understand that payment in full is due on the day of treatment.

_____ _____

Signature Date

Permission to verify information on issued receipt with patient's insurer? (Y / N)