

**New Massage Client Health History**

First Name: \_\_\_\_\_

Last Name: \_\_\_\_\_ IDENTIFY AS:  Female  Male  X

ADDRESS: Street \_\_\_\_\_ DATE OF BIRTH: \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_  
 City \_\_\_\_\_ Year Month Day

Prov \_\_\_\_\_ Postal Code \_\_\_\_\_ OCCUPATION: \_\_\_\_\_

PHONE NUMBER: \_\_\_\_\_ ALTERNATE NUMBER: \_\_\_\_\_

EMAIL: \_\_\_\_\_

EMERGENCY CONTACT: \_\_\_\_\_ PHONE: \_\_\_\_\_

FAMILY PHYSICIAN: \_\_\_\_\_ PHONE: \_\_\_\_\_

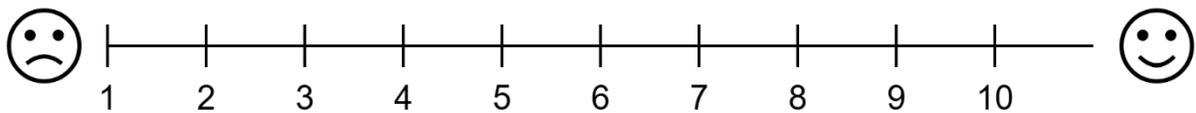
Who referred you:  Healthcare professional-- Name: \_\_\_\_\_  
 or  Other (specify): \_\_\_\_\_

Services you are and/or were receiving and reason: (if other than reason for today's)

Past Present (currently)

- Physiotherapy   reason: \_\_\_\_\_
- Chiropractor   reason: \_\_\_\_\_
- Massage Therapy   reason: \_\_\_\_\_
- Chiropodist   reason: \_\_\_\_\_
- Naturopath   reason: \_\_\_\_\_

**Overall Health**



Reason(s) for massage:

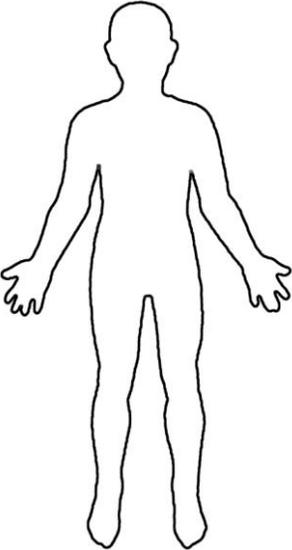
Primary: \_\_\_\_\_

Secondary: \_\_\_\_\_

Have you seen your (primary) physician for this issue? **Yes**  **No**

If yes, are you being treated for it? \_\_\_\_\_

Does it affect your activities of daily living? \_\_\_\_\_

CIRCULATION	NERVOUS SYSTEM	HEAD/NECK																																										
<table border="1" style="width:100%; border-collapse: collapse;"> <thead> <tr> <th style="width:70%;">Conditions</th> <th style="width:15%;">You</th> <th style="width:15%;">Family</th> </tr> </thead> <tbody> <tr> <td>High Blood pressure</td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> </tr> <tr> <td colspan="3">If yes for you, medication:</td> </tr> <tr> <td>High Blood pressure</td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> </tr> <tr> <td colspan="3">If yes, for YOU, how is it managed:</td> </tr> <tr> <td colspan="3"> </td> </tr> <tr> <td>Heart Attack</td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> </tr> <tr> <td>Stroke/CVA</td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> </tr> <tr> <td>Chronic Congestive Heart Failure</td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> </tr> <tr> <td>Pace Maker/Arrhythmia</td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> </tr> <tr> <td>Lymphoedema</td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> </tr> <tr> <td>Varicose Veins</td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> </tr> <tr> <td>Blood Clots</td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> </tr> <tr> <td>Hemophilia</td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> </tr> </tbody> </table> <p style="text-align: center;"><b>RESPIRATORY</b></p> <p><input type="checkbox"/> Difficulty breathing</p> <p><input type="checkbox"/> Chronic cough</p> <p><input type="checkbox"/> Shortness of breath</p> <p><input type="checkbox"/> Bronchitis</p> <p><input type="checkbox"/> Emphysema</p> <p><input type="checkbox"/> TB</p> <p><input type="checkbox"/> Asthma</p> <p>If yes, do you have a puffer with you? _____</p> <p><input type="checkbox"/> Sinus issues: _____</p> <p><input type="checkbox"/> Allergies? _____</p> <p><input type="checkbox"/> Medication if any: _____</p>	Conditions	You	Family	High Blood pressure	<input type="checkbox"/>	<input type="checkbox"/>	If yes for you, medication:			High Blood pressure	<input type="checkbox"/>	<input type="checkbox"/>	If yes, for YOU, how is it managed:						Heart Attack	<input type="checkbox"/>	<input type="checkbox"/>	Stroke/CVA	<input type="checkbox"/>	<input type="checkbox"/>	Chronic Congestive Heart Failure	<input type="checkbox"/>	<input type="checkbox"/>	Pace Maker/Arrhythmia	<input type="checkbox"/>	<input type="checkbox"/>	Lymphoedema	<input type="checkbox"/>	<input type="checkbox"/>	Varicose Veins	<input type="checkbox"/>	<input type="checkbox"/>	Blood Clots	<input type="checkbox"/>	<input type="checkbox"/>	Hemophilia	<input type="checkbox"/>	<input type="checkbox"/>	<p><input type="checkbox"/> Herpes/shingles</p> <p><input type="checkbox"/> Epilepsy/seizures</p> <p><input type="checkbox"/> MS/Parkinson's</p> <p>Medication for any of the above: _____</p> <p><input type="checkbox"/> Loss of sensation</p> <p><input type="checkbox"/> Weakness,</p> <p><input type="checkbox"/> Pins and needles</p> <p>If yes, please circle on figure:</p> <div style="text-align: center;">  </div>	<p><input type="checkbox"/> Headaches</p> <p><input type="checkbox"/> Migraines</p> <p><input type="checkbox"/> Vision Loss/problems</p> <p><input type="checkbox"/> Ear problems</p> <p><input type="checkbox"/> Hearing loss/aids</p> <p><input type="checkbox"/> Dizziness</p> <p><input type="checkbox"/> Head injury</p> <p><input type="checkbox"/> TMJ/jaw</p> <p>If yes, do you wear a mouth guard? <input type="checkbox"/> YES    <input type="checkbox"/> NO</p> <hr/> <p style="text-align: center;"><b>SKIN</b></p> <p><input type="checkbox"/> Infections/warts/fungus</p> <p><input type="checkbox"/> Allergies</p> <p><input type="checkbox"/> Rashes</p> <p><input type="checkbox"/> Hepatitis</p> <hr/> <p style="text-align: center;"><b>OTHER CONDITIONS</b></p> <p><input type="checkbox"/> Diabetes</p> <p><input type="checkbox"/> Cancer/tumour</p> <p>If yes, are you currently being treated: _____</p> <p><input type="checkbox"/> Fibromyalgia</p> <p><input type="checkbox"/> Mental health Issues</p>
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	<p style="text-align: center;"><b>DIGESTION</b></p> <p><input type="checkbox"/> Constipation</p> <p><input type="checkbox"/> Diarrhea</p> <p><input type="checkbox"/> Irritable bowel syndrome</p> <p><input type="checkbox"/> Crohn's/Colitis</p> <p><input type="checkbox"/> Gerd/Acid reflux</p>	<p style="text-align: center;"><b>REPRODUCTIVE</b></p> <p><input type="checkbox"/> Pregnant:</p> <p>If yes, how many weeks? _____</p> <p>Due date: _____</p> <p>Number of pregnancies? _____</p> <p><input type="checkbox"/> C-sections:# _____</p> <p>Gynecological conditions: _____</p> <p>Menopause: _____</p>																																										



Please CHECK (v) the boxes if you give consent.

#### INFORMED CONSENT TO MASSAGE THERAPY TREATMENT

- I hereby consent for my therapist to treat me with massage therapy as per the scope of practice defined by the College of Massage Therapist of Ontario including assessments, examinations and techniques, which may be recommended, by my therapist including various modes of remedial exercise and hydrotherapy (hot and cold).
- I acknowledge that the therapist is not a physician and does not diagnose illness or disease or any other physical or mental disorder nor is massage therapy a substitute for a medical examination.  
I acknowledge that no assurance or guarantee has been provided to me as to the results of the treatment.  
I acknowledge that with any treatment there can be risks which will be explained to me prior to treatment.  
I assume those risks which may include muscles soreness, tenderness and possible bruising.
- I acknowledge and understand that the therapist must be fully aware of my existing medical conditions.  
I have completed my medical history form as provided by my therapist and disclosed to the therapist all those medical conditions affecting me.  
It is my responsibility to keep the massage therapist updated on my medical history. The information I have provided is true and complete to the best of my knowledge.
- I am informed that I have the right to terminate the treatment at any time, and the right to alter the therapist's pressure during the massage treatment.
- I authorize my therapist to release or obtain information pertaining to my conditions(s) and/or treatment to/from:
  - other caregivers (circle of care)
  - third-party payers (insurance)as per the "Personal Health Information Protection Act"
- I give consent to receive periodic e-mails and newsletters from Mountain Chiropractic and Natural Health which may include appointment reminders, schedule changes, promotions and other helpful information which we wish to share with our clients.

#### POLICY

- Massage therapy is booked by appointment only.**  
**Please provide 24 hours notice to cancel an appointment or fees will be applied.**

I understand the above policies and by signing below agree to the terms.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

NAME: \_\_\_\_\_