Mississauga Therapeutic Massage

Health History Form

For your information:
All information on this form and in your file is confidential except as required or allowed by law or to facilitate a diagnosis (assessment) or treatment. You will be asked to provide written authorization for release of any information. If your health status changes in the future, please let us know.

Name:_____ Date:_____

Tel: res.:_____

Address:_____ bus.:_____

_____ Fax/email:_____

Date of Birth: M_____ D_____ Y_____ Occupation:_____

What is your primary complaint?:_____

What is your general health status? _____

Who referred you?_____ Their address?_____

Health history: Please indicate conditions you are experiencing, or have experienced

Respiratory
- ❑ Chronic cough
- ❑ Shortness of breath
- ❑ Bronchitis
- ❑ Asthma
- ❑ Emphysema
- ❑ Sinus infection

Cardiovascular
- ❑ High blood pressure
- ❑ Low blood pressure
- ❑ CCHF
- ❑ Heart attach/MI
- ❑ Varicose veins
- ❑ Phlebitis
- ❑ Stroke/CVA
- ❑ Pacemaker or similar devices

Infection
- ❑ Hepatitis
- ❑ TB
- ❑ HIV
- ❑ Infectious skin conditions

Skin
- ❑ Skin conditions_____.

Other conditions
- ❑ Loss of sensation
- ❑ Diabetes (onset:_____)
- ❑ Allergies (i.e. anaphylaxis or skin irritation)
- ❑ Epilepsy
- ❑ Arthritis
- ❑ Cancer
- ❑ Fibromyalgia
- ❑ Urinary disorders
- ❑ Kidney disorders
- ❑ Digestive disorders
- ❑ Liver disorders
- ❑ Hernia

Head/neck
- ❑ Vision problems
- ❑ Vision loss
- ❑ Ear problems
- ❑ Hearing loss

Women
- ❑ Pregnant (due:_____)
- ❑ Gynecological conditions
- ❑ Menopause

Soft tissue/joint discomfort and its nature

Head_____

Neck_____

Low back_____

Mid back_____

Upper back_____

Shoulders L R_____

Arms L R_____

Legs L R_____

Knees L R_____

Other_____

Current Medication_____

_____

Conditions it treats_____

Surgery_____ **Date:**_____

Nature_____

Injury_____ **Date:**_____

Nature_____.

Primary Physician_____

Address_____

_____

Present involvement in other care **Yes** **No**

If "Yes" please specify:_____

_____

Other Medical Conditions (e.g. mood disorders, sleep disorders, hemophilia, etc.)_____

_____

Of special note: (presence of internal pins, wires, artificial joints, special equipment) _____

_____

Mississauga Therapeutic Massage

Health History Update

Date: _____ Signature: _____

Date: _____ Signature: _____

Date: _____ Signature: _____

Privacy Policy

I understand that to provide me with massage therapy treatments, my therapist, as a Health Information Custodian (HIC), will collect personal information from me.

I have reviewed the written statement (see www.missrmt.ca under online booking) indicating the purposes for collection, use, and disclosure of my personal health information. I understand that my therapist will only collect, use, and disclose my personal information with my consent, for the purposes indicated in the written statement, unless the collection, use, or disclosure is required or permitted by law without my consent.

Cancellation Policy

24 hours notice is required for all cancellations/missed appointments. For cancellations with less than 24 hours notice, a charge of 50% of the appointment fee will apply.

A late arrival will cut into the treatment time allotted, and the fee charged will be for the time booked. In the instance that the RMT is late, the treatment will be for the full time booked.

Consent to Treatment

I, of my own will, consent to be treated for the following condition: _____

I acknowledge that my therapist has provided me with such information as is pertinent to the treatment for the above listed complaint. Alternative course of treatment (were applicable and relevant) have been explained to me, as well as possible benefits, risks and side effects, if any, with regard to my therapist's proposed treatment plan.

I feel that I fully understand what is involved in the proposed treatment and what the possible consequences of not having the treatment may be.

I acknowledge that, for the purpose of integrated therapy, the following areas may be addressed during the course of the treatment: head, neck and shoulders, upper chest, arms, back and hips, abdomen, buttocks, legs, hands and feet, (breasts are excluded unless specifically indicated for clinical reasons, in which case a separate consent form will be issued).

I understand that I may change my mind regarding any aspect of my treatment at any time and upon informing my therapist of my decision, I may withdraw consent with the intent to alter or discontinue the treatment.

In compliance with the "Consent to Treatment Act" (Bill 109), I provide my full, voluntary, informed consent to treatment. I intend this consent to pertain to my entire course of treatment.

Signature: Date: