Massage
Health History Form

The information request below will assist us in treating you safely. Feel free to ask any questions about the information requested. Please note that all information provided below will be kept confidential unless allowed or required by law. Your written permission will be required to release any information.

Name: ____________________ Phone: ____________________
Address: ____________________
Occupation: ____________________ Date of Birth ____________________
Have you received massage therapy before? ☐ Yes ☐ No
Did a health care practitioner refer you for massage therapy? ☐ Yes ☐ No
If yes, please provide their name and address ____________________

Cardiovascular
- ☐ high blood pressure
- ☐ low blood pressure
- ☐ chronic congestive heart failure
- ☐ heart attack
- ☐ phlebitis / varicose veins
- ☐ stroke / CVA
- ☐ pacemaker of similar device
- ☐ heart disease

Is there a family history of any of the above?
☐ Yes ☐ No

Respiratory
- ☐ chronic cough
- ☐ shortness of breath
- ☐ bronchitis
- ☐ asthma
- ☐ emphysema

Is there a family history of any of the above?
☐ Yes ☐ No

Infections
- ☐ hepatitis
- ☐ skin conditions
- ☐ TB
- ☐ HIV
- ☐ herpes

Other Conditions
- ☐ loss of sensation, where? ____________________
- ☐ diabetes, onset: ____________________
- ☐ allergies/ hypersensitivity to What? ____________________
  type of reaction: ____________________
- ☐ epilepsy
- ☐ cancer, where? ____________________
- ☐ skin conditions, what? ____________________
- ☐ arthritis

Is there a family history of arthritis?
☐ Yes ☐ No

Head / Neck
- ☐ history of headaches
- ☐ history of migraines
- ☐ vision problems
- ☐ vision loss
- ☐ ear problems

Women
- ☐ pregnant, due ____________________
- ☐ gynaecological conditions, what? ____________________

Overall, how is your general health? ____________________

Primary Care Physician: ____________________

Address: ____________________

Current Medications: ____________________
Condition it treats: ____________________

Are you currently receiving treatment from another health care professional? ☐ Yes ☐ No
If yes, for what? ____________________

Surgery – Date: ____________________
Nature: ____________________

Injury – Date: ____________________
Nature: ____________________

Do you have any other medical conditions? (e.g digestive conditions, hemophilia, osteoporosis, mental illness)
☐ Yes ☐ No
What? ____________________

Do you have any internal pins, wires, artificial joints or special equipment? ☐ Yes ☐ No
what? ____________________
where? ____________________

What is the reason you are seeking massage therapy? Please include the location of any tissue or joint discomfort. ____________________

Date of initial Health History: ____________________
Update 1 ____________________
Update 2 ____________________
Update 3 ____________________

Informed Consent

I (client's name) ___________________________ understand that by signing this form I am choosing to proceed with massage therapy treatment. I understand that I may change my mind, alter or refuse treatment at any time during this or any other treatment. I understand that the massage therapist follows mandatory reporting procedures and that all information given to the massage therapist will be strictly confidential. The only times when my information may be seen by anyone other than myself or the massage therapist is with my written consent, if the massage therapist is court ordered for my records, or for the purpose of billing insurance companies. I understand that any assessment done by my massage therapist cannot diagnose a problem, but is used as a measure to rule out any potential contraindications to massage. I understand that massage therapists do not diagnose illness or disease or perform any spinal manipulations, nor do they prescribe any medical treatments, and nothing said or done during the sessions should be construed as such. I understand that massage therapy is not a substitute for medical examination or diagnosis and that I should seek an alternative health care provider for those services.

I understand that the massage I receive is for the purpose of stress reduction and relief from muscular tension, spasm or pain and to increase circulation. If I experience any pain or discomfort, I will immediately inform the massage therapist so that the pressure or methods can be adjusted to my comfort level. Because massage therapy should not be performed under certain circumstances, I confirm that all information on my health history form is correct and up to date, I agree to keep the massage therapist updated as to any changes in my health, and I release the massage therapist from any liability if I fail to do so.

Client's Signature: ___________________________________ Date:________________________________

Therapist's Signature: ______________________________ Date: _______________________________

Signature of Guardian/Substitute Decision Maker:________________________ Date:_________________

Treatment Fee Schedule

	Child (14 and Under)	Student/Senior	Adult
30 Minute	$35+HST	$45+HST	$50+HST
45 Minute	$40+HST	$55+HST	$60+HST
1 Hour	$50+HST	$65+HST	$70+HST

Missed Appointment/Cancellation Policy

12 hours notice is required for cancellation of an appointment allowing for the therapist to fill the available space. If notice is not provided, a missed appointment fee will be charged. The Missed Appointment fee is equal to half the amount of the treatment. If clients are late, full fees for the scheduled appointment time will apply. Clients arriving 15 minutes late or more will automatically be rescheduled and a missed appointment fee will be charged.

I ______________ (print name of client or Substitute Decision Maker) have read and understand the Treatment Fee Schedule and the Missed Appointment/Cancellation Policy. By signing this form I agree to be responsible for payment in full for all and any incurred expenses set by the Treatment Fee Schedule and Missed Appointment/Cancellation Policy.

Signature: ____________________ Date: _____________