PETERBOROUGH
WELLNESS GROUP

291 Charlotte St. Peterborough, ON K9H2V6 705 748 6611

Massage Health History Form

Name:_____ Email:_____

Preferred Name:(if different):_____ Phone:_____

Street Address:_____ City:_____

Province:_____ Country: _____ Postal Code: _____

Date of Birth:_____ (DD/MM/YYYY) Occupation:_____

Emerg Contact:_____ Emerg Contact Phone:_____

Emerg Contact Relation:_____ How Did You Hear About Us:_____

Do you require any accessibility/mobility accommodations? _____

_____

_____

Please provide the name and address of your primary care physician*_____

_____

Have you received massage therapy before? Y / N

Did a health care provider refer you for massage? Y / N If you answered yes to the above question, Please provide their name and address (if different form your primary care provider):_____

How would you rate you general health? 1-Poor----------2-Average----------3-Good---------- 4-Great
What is your physical activity level? Sedentary or immobile --------- Minimal---------Moderate----------Athletic

PLEASE INDICATE CONDITIONS YOU ARE EXPERIENCING OR HAVE EXPERIENCED BELOW.

Cardiovascular

☐ High blood pressure ☐ Low blood pressure ☐ Heart attack ☐ Stroke/CVA ☐ Pacemaker or similar device

☐ Heart disease ☐ Varicose veins/phlebitis

Respiratory

☐ Chronic Cough ☐ Shortness of breath ☐ Bronchitis ☐ Asthma ☐ Emphysema

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Head/Neck

☐ History of headaches ☐ History of Migraines ☐ Vision problems ☐ Hearing loss

☐ History of whiplash

Conditions or Disorders relevant to Massage Therapy Treatment:

☐ Loss of sensation, where?

☐ Diabetes, onset:

☐ Allergies/hypersensitivity to what? And type of reaction?

☐ Epilepsy

☐ Cancer, Where? Stage? Treatment?

☐ Arthritis

☐ Osteopenia/osteoporosis

☐ Muscle, skin, joint and/or bone pain

☐ Inflammatory conditions

☐ Increased sensitivity to pain or pressure

☐ Immune conditions/disorders

☐ Reproductive system disorders/conditions

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☐ Bruises easily

☐ Presence of internal plates, screws, artificial joints, or other medical devices

☐ Contagious skin conditions

☐ Eczema or psoriasis

Please list any surgeries you've had and their dates

Please list any medications you are on and what they are prescribed for

Do you have any other medical conditions not listed above that you feel your RMT needs to know in order to provide you with safe and effective massage therapy treatment.

Please list any past or present injuries that are relevant to your treatment

What is the reason you're seeking massage therapy?

Describe what you're feeling

How long have you been experiencing this?

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Is this problem:

☐Getting better

☐Staying the same

☐Getting worse

What makes it feel better?

What makes it worse?

Is this problem interfering with:

☐Work

☐Sleep

☐Daily routine

☐Exercise

☐Other

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Consents

Communication

Appointment Notifications and Reminders

Text Message(SMS)

Standard messaging & rates may apply, messaging frequency can vary and you can update your preferences anytime.

☐ Text Message(SMS) 2 days before appointment
☐ Text Message(SMS) 2 hours before appointment
☐ Text Message(SMS) 24 hours before appointment

Massage Therapy Health History- Consents

Accuracy of Information – ***Required***

☐ *I certify that the medical information provided is correct to my knowledge.*

Privacy and Sharing of Information – ***Required***

I authorize the clinic and its associated health professionals to collect my personal and medical information as documented. In addition, I authorize the clinic and its associated health professionals to communicate with my family doctor and/or referring doctor as deemed necessary for my beneficial treatment. I also understand that my personal and medical information is confidential and will only be disclosed to third parties with my permission.

☐ ***I agree***

Cancellation Policy- ***Required***

Your appointment time is reserved just for you. A late cancellation or missed visit leaves a hole in the therapists' day that could have been filled by another patient. As such, we require 24 hrs notice for any cancellations or changes to your appointment. Patients who provide less than 24 hrs notice, or miss their appointment, will be charged a cancellation fee with half of the book massage amount.

☐ ***I am aware of the Cancellation Policy.***

Signature – ***Required***

Patients Name: _____

Date: _____