Health History Form

The information requested below will assist us in treating you safely. Feel free to ask questions about the information being requested. Please note that all information provided below will be kept confidential unless written permission is given or requested by law.

Name: _____ Cell Phone: _____

Address: _____

Email: _____ Home Phone:_____

Date of Birth: _____ Occupation: _____

Emergency Contact Name and Phone:_____

Have you had massage therapy before? Yes ____ No___

What other treatments have you had or are currently having: Physio____ Chiropractic_____ Osteopathic ____ Naturopath _____

Did a health care practitioner refer you for massage therapy? Yes ____ No_____

Primary Care Physicians Name and phone number _____

What is your general overall health? _____

What is the reason you are seeking Massage Therapy? _____

Please list Medications, including Over-the-counter pharmaceuticals

Please list past surgeries, approximate dates and any current symptoms

_____

_____

Please indicate any car accidents or major injuries, dates and any current symptoms

_____

Do you have any internal pins, wires artificial joints or special equipment?

_____

Please indicate conditions you are experiencing or have experienced in the past, as it may be relevant.

Muscle/Joints/Nerves

- Migraine Headaches
- History of Headaches
- Whiplash
- Tooth/Jaw/Ear Pain
- Head Trauma/Concussion
- Arm pain/Tingling/weakness
- Neck Pain
- Back Pain/ Injury
- Degenerating Disks
- Poor Posture
- Dislocations
- Sciatica/Hip Pain
- Scoliosis
- Leg pain/ Tingling/Weakness
- Strain/Sprain
- Tendonitis/Fibrositis/Bursitis
- Joint Stiffness/Pain
- Osteo/Rheumatoid arthritis
- Family History of Arthritis
- Muscle / Nerve Disease
- Multiple Sclerosis
- Fibromyalgia
- Paralysis
- Loss of Coordination
- Vision Problems
- Vision Loss
- Hearing Loss
- Ringing in the ears

Cardiovasular

- High/low Blood Pressure
- Heart Attack/Stroke
- Chronic Congestive Heart Failure
- Pacemaker
- Varicose Veins/ Phlebitis
- Heart Disease
- Family History of Heart Disease
- Lightheaded /Fatigued
- Chest Pain/Angina
- Arteriosclerosis
- Hemophilia
- Aneurysm
- Raynauds/Beurger's Disease
- Poor Circulation, Swelling

Respiratory

- Shortness of Breath
- Emphysema
- Chronic Cough/Bronchitis
- Asthma
- Family History of Asthma
- Sinus Infection
- Congestion/Frequent Colds
- Smoking
- Pneumonia
- Tuberculosis

Digestive

- Poor Digestion/Gas/Nausea
- Constipation/Diarrhea
- Diabetes
- Ulcers
- Hernia & Type

Skin

- Poor Healing/Bruising
- Sensitive/Dry Skin
- Plantar Warts
- Shingles
- Cold Sores
- Skin Conditions
- Eczema
- Psoriasis
- Rashes/Eruptions

Woman

- Menstrual/Gynecological Problems
- List issues _____
- Menopausal Problems
- _____ _____
- Pregnant: Due Date:_____ __
- Number of Children _____
- Fibroids/Cysts
- Mastectomy

Other

- Allergies Reaction_____
- Gout
- Epilepsy
- Insomnia
- Fractures/Bone Disease
- Hepatitis
- Cancer:_____ _____-
- Loss of Sensation
- Dizziness/Fainting
- Mental Illness
- HIV
- Herpes

Please list any health conditions you may have or had which are not listed:

Guidelines and Procedures for Massage Therapy Revised - June 2020

- COVID Pre Screening prior to appointment
- COVID Screening the day of the appointment prior to beginning treatment
- Signage indicating COVID 19 symptoms
- **Client will be required to wash their hands with soap and water, or use hand sanitizer before and after treatments**
- **Please arrive with your mask on. Masks will be mandatory for both client and therapist for the duration of the appointment. For clients, the mask may be cloth or disposable. Please supply your own masks.**
- Arrival times: If you arrive more than 5 minutes prior to your appointment time, please wait in your car to minimize waiting room congestion.
- Seating in the waiting room has been adjusted to provide social distance
- Please arrive alone for your appointment (where possible) If the client requires assistance please note the visitor will also be required to have a COVID screening, wear a mask for the duration of the visit and wash their hands.
- RMT will be keeping a daily log listing the clients name, and phone number for the purpose of contact tracing if required
- Appointment times/availability will change slightly as there will be more time required between clients to implement cleaning procedures.
- In addition to routine cleaning, high touch surfaces will be disinfected through out the day, and treatment rooms will be cleaned and disinfected

INFORMED CONSENT TO MASSAGE THERAPY TREATMENT:

I understand that the massage therapist is providing massage therapy services within their scope of practice. I hereby consent for my therapist to treat me with massage therapy for the issues discussed and noted in the client chart including such assessments, examinations and techniques, which may be recommended, by my therapist. I acknowledge that the therapist is not a physician and does not diagnose illness or disease or any other physical or mental disorder. I clearly understand that massage therapy is not 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 and those risks have been explained to me and I assume those risks. 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 of 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 authorize my therapist to release or obtain information pertaining to my condition(s) and/or treatment to/from my other caregivers.

I have read the Guidelines and Procedures for Massage Therapy as noted above. I understand the information as provided by the therapist and as per the regulatory bodies regarding the measures taken to lessen the risk of transmission of COVID-19, I consent to treatment understanding the above measures have been implemented.

I have read the above noted consent and I have had the opportunity to question the contents and my therapy. By signing this form, I confirm my consent to treatment and intend this consent to cover the treatment discussed with me and such additional treatment as proposed by my therapist from time to time, to deal with my physical condition and for which I have sought treatment. I understand that at any time I may withdraw my consent and treatment will be stopped.

Clients Name:_____ Date:_____

Client Signature: _____

Tara Sharpe
60 Bridgeport Rd. East, Suite 103
Waterloo, ON N2J 2J9
Email: tarasharpe2@gmail.com
www.tarasharpe.ca
519-572-7428