Heritage Park Physical Therapy
1A - 210 Lorraine Avenue
Kitchener, ON
N2B 3T4
519-893-8800

Massage Therapy Health History Form

The information request below will assist us in treating you safely. Feel free to ask any questions about the information being 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: **City:** **Prov:** **Postal Code:**

Email:

Occupation: **Date of Birth:**
MM DD YYYY

Have you received massage therapy before? YES NO

Did a health care practitioner refer you for massage therapy? YES NO **Name:**

Primary Care Physician: **Address:** **Phone:**

Please indicate conditions you are experiencing or have experienced:

Cardiovascular

- High Blood Pressure
- Low Blood Pressure
- Chronic Congestive Heart Failure
- Heart Attack
- Phlebitis/Varicose Veins
- Stroke/CVA
- Pacemaker or Similar Device
- Other (please list):

Is there a family history of any of the above?
YES NO
If yes, what?

Respiratory

- Chronic Cough
- Shortness of Breath
- Bronchitis
- Asthma
- Emphysema
- Other, please list:

Is there a family history of any of the above?
YES NO
If yes, what?

Overall, how is your general health?

How much conversation are you comfortable with during your treatment?
None Minimal Moderate

Infections

- Hepatitis
- Herpes
- TB
- HIV
- Skin Infections:
- Other (please list):

- Loss of sensation, where?

Numbness, tingling? Where?

- Allergies/hypersensitivity?

What? Lotions Oils Other
If other, what?
Type of Reaction(s):

- Epilepsy
- Cancer

If so, what kind?

- Skin conditions, what?:

- Arthritis, what type?

Location:

Is there a family history of any of the above?
YES **NO**
Please specify:

- Diabetes, onset:

Type: Type 1 Type2

Head/Neck

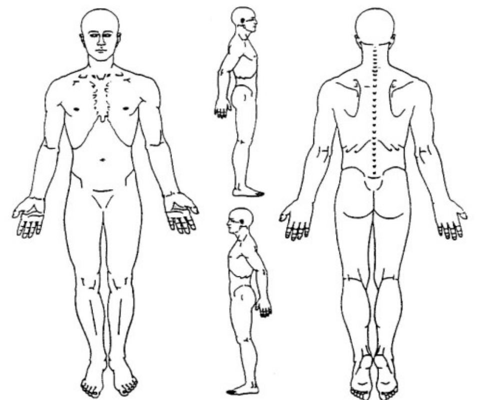
- History of headaches
- History of migraines
- Vision problems
- Vision loss
- Ear problems
- Hearing loss
- Other (please list):

Women

- Pregnant, due:
- Gynaecological conditions

Condition:

Please circle or draw an arrow to the areas where you are experiencing pain or discomfort.



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, haemophilia, osteoporosis, mental illness?)***

YES **NO**

If yes, please list:

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

YES NO

Region:

What is the reason you are seeking massage therapy?

Please include the location of any tissue or joint discomfort.

I understand that the massage I receive is provided for the basic purpose of relaxation, stress reduction, and/or relief of muscular tension within the scope of practice as defined by the College of Massage Therapists of Ontario.

I further understand that the massage should not be construed as a substitute for medical examination, diagnosis, or treatment and that I should see a physician, chiropractor, or other qualified medical specialist for any mental or physical ailments that I am aware of.

I understand that massage therapists are not qualified to perform skeletal adjustments, diagnose and/ or prescribe, and that nothing said in the course of the session should be construed as such.

Because massage is contraindicated under certain conditions, I affirm that I have stated all my known medical conditions and answered all questions honestly. I agree to keep the therapist updated as to any changes in my medical profile and understand that there shall be no liability on the therapist's part should I forget to do so.

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

Name (Please Print):

Signature: Date:

Missed/ Cancellation Appointment Policy

The office requires 24-hour notice for cancellation of Massage Therapy Appointments. Appointments missed or cancelled without sufficient notice will be charged the cost of the treatment.

From time to time your Insurance Company may audit you for dates and treatments, signing below gives Heritage Park Physical Therapy permission to release Account Statement information to the company upon their request.

Late appointments will be billed for the original treatment time/length that was initially booked. We ask all patients to arrive 5-10 minutes before their scheduled appointment to go over health history, questions, etc.

I have read, understood, and agreed to the fees and payment obligations as indicated.

Patient (or parent/guardian) Name:

Signature: Date: