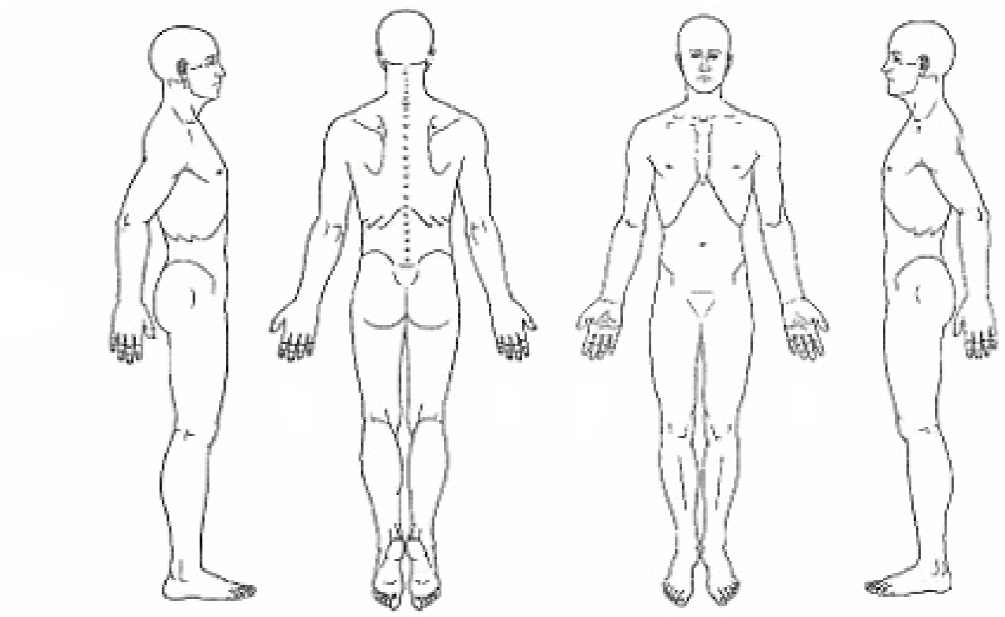
MASSAGE HEALTH HISTORY FORM

Name: _____ Today's Date: _____
Address: _____ City: _____ Prov: _____
Postal Code: _____ Telephone: _____ Cell: _____
Date of Birth: _____ Email:_____
Would you like to receive emails? Yes No (we will not share your information)
Occupation: _____ Employer: _____
Emergency Contact: _____ Relationship: _____
How did you hear about us? _____

Main Complaint

What is your primary complaint?: _____
Location of the pain. Please circle on the diagrams. Try to be as specific as you can.



Cause of the pain:_____
How long have you had the pain? _____
How frequent is the pain? (all day/night/only when you get up?) _____
How intense is the pain? (scale of 1 –10) _____
How would you describe the pain? (achy, throbbing, burning) _____
What makes the pain increase? _____
What makes the pain decrease? _____
What medications are you presently taking for the condition (muscle relaxants, painkillers?)?

_____
Is there a history of this condition? _____
Have you received any other treatment for this condition? If yes, please describe:

_____
What results do you desire from your treatment? _____

General health status

Current Medications: _____

_____

Conditions they treat: _____

Recent Special Testing (blood work, x-rays, MRI, etc.)_____

Injuries / Fractures: _____

Surgeries: _____

Do you smoke? No Yes (how much daily? _____) Do you exercise? No Yes (how often? _____ type _____)

Present involvement in other health care?: No Yes If yes, what other therapy are you receiving?

_____

Other Medical Conditions (i.e. digestive conditions, gynecological conditions, hemophilia, emotional or mental illness, etc.) _____

_____

Of Special Note (presence of internal pins, wires, artificial joints, special equipment, etc.):

_____

Please check circle(s) to indicate any conditions you are experiencing

Respiratory

O Chronic cough
O Shortness of breath
O Bronchitis
O Asthma
O Emphysema

Cardiovascular

O High or Low Blood pressure
O Heart attack
O Phlebitis
O Stroke/CVA
O Pacemaker or similar device
O Heart disease
O Easy bruising
O Varicose Veins
O Blood clots or clotting disorder

Soft Tissue/Joint Discomfort

O Neck
O Low Back
O Mid back
O Upper back
O Shoulders
O Elbows
O Wrists / Hands
O Arms
O Hips
O Knees Ankles / Feet
O Legs
O Muscle Cramping
O Jaw
O Weakness or Paralysis
(where? _____)
O Other:
_____

Infections

O Hepatitis
O HIV AIDS
O Skin
O Plantars warts
O Other: _____

Head/Neck

O Vision problems
O Ear problems (e.g. fullness, ringing, loss of hearing)
O Head trauma
O Headaches/Migraines
O Sinus problems
O Past whiplash injury

Women

O Pregnant (how far along? _____)
O Birth Control (method: _____)

Other Conditions

O Loss of sensation
O Numbness/Tingling
O Dizziness
O Fainting
O Diabetes (type: _____ controlled? Yes No)
O Cancer
O Arthritis (type: _____)
O Skin condition
O Chronic Fatigue or Fibromyalgia
O Disc Herniation
O Scoliosis
O Osteoporosis
O Bone disease
O Spinal conditions
O Allergies
O Epilepsy

INFORMED CONSENT TO MASSAGE THERAPY TREATMENT

I understand that the massage therapist is providing massage therapy services within their scope of practice as defined by the Massage Therapist Association of Nova Scotia.

I hereby consent for my therapist to treat me with massage therapy for the above noted purposes 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. It is recommended that I attend my personal physician for any ailments that I may be experiencing. 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. , the client disrobes to their comfort level, and lies on a table between two sheets. Only the areas of the body being directly treated are uncovered one time. If at any time you are uncomfortable with the pressure or technique being used, you can tell the therapist (i.e. to decrease or increase pressure, irritating, etc). You can also stop the treatment at any time.

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 or third party payers.

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.

Name (printed) _____ Signature of Patient/Guardian _____

Date Signed _____

Therapist Signature _____

Date Signed _____