HEALTH HISTORY FORM

Name:
Address:
City/Postal Code:
Date:
Occupation:
Date of Birth:
Home Phone:
Cell/work phone:

Have you received massage therapy before? []yes []no
What results are you expecting from this session?

Did a health care practitioner refer you for massage? []yes []no
If yes please provide name and address:

Your email:

Are you currently receiving treatment from another health care professional? [] yes [] no
If yes for what?

NAME(S) OF CURRENT MEDICATION(S):	CONDITION IT TREATS:
1.	
2.	
3.	
4.	

SURGERY/ACCIDENTS:	
1.	Year:
2.	Year:
3.	Year:

PLEASE INDICATE CONDITIONS YOU ARE EXPERIENCING OR HAVE EXPERIENCED:

Head/Neck
[ ] history of headaches
[ ] history of migraines
[ ] vision problems
[ ] vision loss
[ ] ear problems
[ ] hearing loss

Respiratory
[ ] chronic cough
[ ] shortness of breath
[ ] bronchitis
[ ] asthma/emphysema
[ ] smoker
[ ] Is there any family history of the above? [ ]yes [ ] no

Infections
[ ] hepatitis/ HIV/AIDS
[ ] skin conditions
[ ] TB
[ ] herpes

Other Conditions
[ ] loss of sensation, where? ____________________
[ ] diabetes, onset: ______________
[ ] allergies/hypersensitivity to what? ______________
[ ] type of reaction: ______________
[ ] epilepsy
[ ] cancer______________
[ ] skin conditions, what? ____________________
[ ] arthritis ______________

Is there a family history of arthritis? [ ] yes [ ] no

Overall, how is your general health? ______________

Primary Care Physician: ______________
Address:______________

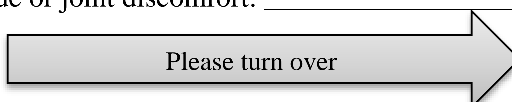
Cardiovascular
[ ] high blood pressure
[ ] low blood pressure
[ ] heart disease
[ ] chronic congestive heart failure
[ ] heart attack
[ ] stroke/CVA
[ ] pacemaker or similar device
[ ] phlebitis/varicose veins/ blood clots
[ ] Is their family history of any of the above? [ ] yes [ ]no

Women Only
[ ] pregnant? due: ______________
[ ] gynecological conditions, ______________

Other Medical Conditions: ______________

Do you have any other conditions or concerns you feel your therapist should know about? (mental health issues or special needs) You may also speak to your therapist in private with any other questions or concerns.

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 indicate the location of any tissue or joint discomfort: ______________


Please turn over

THE COST OF OUR SERVICES

30 minutes- $60.00	60 minutes- $95.00	90 minutes- $135.00
45 minutes- $77.00	75 minutes- $115.00	120 minutes- $177.00

Prices include HST

CANCELLATION POLICY: I understand that I must notify the office **24 hours** in advance of my cancelling my appointment or pay for the full price of my appointment. I am responsible for the cost of my appointment even if I do not receive a reminder email or call.

CONSENT FOR TREATMENT (*please initial*) At any time before or during the massage I can ask the therapist to alter or stop the treatment. The information on this form is complete and accurate to the best of my knowledge and I will update any changes in my health. The booked appointment duration in minutes includes the consultation/assessment, time to get on table, hand washing, brief charting of consultation/assessment and massage therapy.

______ *I consent to treatment*

______ *I do not consent to treatment*

CONSENT FOR ELECTRONIC COMMUNICATION (*please initial*)
Canada's Anti-Spam Legislation (CASL) requires that we obtain your express consent to receive any electronic communications from us.

______ *I consent to email marketing*

______ *I do not consent to email marketing*

INSURANCE CONSENT(*please initial)* If you choose to submit any receipt(s) to a third party for reimbursement, that third party may contact us to validate your submission. By submitting a receipt issued by us, or bearing our information, you are consenting to allow us to communicate to the third party you have submitted to. Kanata Massage Therapy validates the date, duration, time, cost and therapist.

People who submit false insurance claims bearing our information may be discharged from the clinic. When insurance fraud occurs, we have various obligations to contact the police, the Insurance Bureau of Canada and/or the Professional Conduct Department at CMTO.

______ *I consent to insurance communication*

_____ *I do not consent to insurance Communication.*

____
Client's Signature of Consent

____
Date

____
Please Print Name

<u>Updated by Client</u>

Date	**Signature**