Peterborough Massage Therapy Clinic
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 confidentially unless allowed or required by law. Your written permission will be required to release any information.

Name:_____Date:_____Phone #:_____
Address:_____City:_____ Postal Code:_____
E-mail:_____
Occupation:_____ Date of Birth (mm/dd/yy):_____Referred By:_____
Emergency Contact Name:_____ Phone #:_____
Have you received massage therapy before? Y□ N□
Have you been referred for massage therapy by a healthcare practitioner? Y□ N□
If yes, please provide the name and address of the healthcare practitioner:_____
_____

Please indicate any health conditions you are experiencing or have experienced below:

Cardiovascular
- □ High blood pressure
- □ Low blood pressure
- □ Chronic congestive heart failure
- □ Heart attack
- □ Phlebitis/varicose veins
- □ Stroke/CVA
- □ Pacemaker or similar device
- □ Heart disease

Is there a family history of any of the above? Y□ N□

Respiratory
- □ Chronic cough
- □ Shortness of breath
- □ Bronchitis
- □ Asthma
- □ Emphysema

Is there a family history of any of the above? Y□ N□

Infections
- □ Hepatitis
- □ TB
- □ HIV
- □ Herpes
- □ Contagious skin conditions (ie: warts)

Other Conditions
- □ Loss of sensation, where? _____
- □ Diabetes, Type I or II? Onset?_____ _____
- □ Allergies or Hypersensitivities, to what?_____ _____ Type of reaction?_____ _____
- □ Epilepsy
- □ Cancer, type/where? _____
- □ Skin conditions, what? _____
- □ Arthritis, type?_____ _____

Is there a family history of arthritis? Y□ N□

Head/Neck
- □ History of headaches
- □ History of migraines
- □ Vision problems
- □ Vision loss
- □ Ear problems
- □ Hearing loss
- □ Recent concussion
- □ Whiplash injury

Women
- □ Pregnant, due date:_____ _____
- □ Gynaecological conditions, what?_____ _____

General
Please indicate any health conditions not listed that apply to you:
_____
_____
_____
Overall, how is your general health?
_____
Primary Care Physician:
_____
Address:_____
_____

Current Medications:	**Reason for Use:**
Are you currently receiving treatment from another health care professional? Y□ N□ If yes, for what?	Do you have any internal pins, wires, artificial joints or special equipment? Y□ N□ What? Where?
Surgery – Date/Nature	**What is your main reason for seeking massage therapy? Please indicate the location of any tissue or joint discomfort.**
Injury – Date/Nature	***Office Use Only*** Date of Initial Health History:_____ Update 1_____Update 2_____ Update 3_____Update 4_____

Peterborough Massage Therapy Clinic
Policies

All new clients may have a consultation and physical assessment performed by the massage therapist prior to treatment. This is to rule out any existing injuries or health conditions and to ensure that the massage treatment will be safe and effective. There is no extra charge for consultation and/or physical assessment.

All clients are expected to be punctual, as your appointment time has been reserved for you. Late arrivals may still receive treatment for the remainder of their scheduled appointment time at the full cost of the scheduled treatment.

Please provide notice within 24 hours of your scheduled appointment if you wish to cancel. We do not charge a late cancellation fee, however, we do ask that our clients be as considerate as possible when unable to keep an appointment.

Peterborough Massage Therapy Clinic
Informed Consent for Treatment

I_____(print name) understand that the massage therapy treatment I receive is provided for the basic purpose of relaxation, relief of muscular tension and injury rehabilitation as performed within the scope of the practice of massage therapy. If I experience any pain or discomfort during this session, I will immediately inform the massage therapist so that the treatment may be adjusted to my level of comfort.

I further understand that massage therapy should not be construed as a substitute for medical examination, diagnosis or treatment. Because massage therapy should not be performed under certain medical conditions, I affirm that I have stated all of my known medical conditions and that the information given by me on this form is true and accurately reflects my past and present health status. I am aware that there are risks with any massage therapy treatment and I confirm that those risks have been explained to me and I agree to assume those risks. I agree to keep the massage therapist updated as to any changes in my medical profile and understand that there shall be no liability on the massage therapist's part should I fail to do so.

I have read the above noted consent and have been given the opportunity to ask questions regarding consent and the proposed massage therapy treatment. By signing this form, I give consent to receive the massage therapy treatment discussed with me and any subsequent treatments proposed by the massage therapist that have been discussed with me. I understand that I may withdraw my consent at any time by informing the massage therapist and the massage therapy treatments will be stopped.

Client Signature:_____ Date:_____