

Today's Date: _____

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: _____ Phone#: _____

Address: _____ Postal Code: _____

Occupation: _____ Date of Birth: _____

Have you received massage therapy before? Yes No

Did a health care practitioner refer you for massage therapy? Yes No

If yes, please provide their name and address. _____

Please indicate conditions you are experiencing or have experienced:

<p>Cardiovascular</p> <p><input type="checkbox"/> high blood pressure</p> <p><input type="checkbox"/> low blood pressure</p> <p><input type="checkbox"/> chronic congestive heart failure</p> <p><input type="checkbox"/> heart attack</p> <p><input type="checkbox"/> phlebitis/varicose veins</p> <p><input type="checkbox"/> stroke/CVA</p> <p><input type="checkbox"/> pacemaker or similar device</p> <p><input type="checkbox"/> heart disease</p> <p>Is there a family history of any of the above? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Respiratory</p> <p><input type="checkbox"/> chronic cough</p> <p><input type="checkbox"/> shortness of breath</p> <p><input type="checkbox"/> bronchitis</p> <p><input type="checkbox"/> asthma</p> <p><input type="checkbox"/> emphysema</p> <p>Is there a family history of any of the above? <input type="checkbox"/> Yes <input type="checkbox"/> No</p>	<p>Infections</p> <p><input type="checkbox"/> Hepatitis</p> <p><input type="checkbox"/> Skin conditions</p> <p><input type="checkbox"/> TB</p> <p><input type="checkbox"/> HIV</p> <p><input type="checkbox"/> Herpes</p> <p>Other Conditions</p> <p><input type="checkbox"/> Loss of sensation, where? _____</p> <p><input type="checkbox"/> diabetes, onset: _____</p> <p><input type="checkbox"/> allergies/hypersensitivity to what? _____</p> <p><input type="checkbox"/> skin conditions, what? _____</p> <p><input type="checkbox"/> arthritis</p> <p>Is there a family history of any of the above? <input type="checkbox"/> Yes <input type="checkbox"/> No</p>	<p>Head/Neck</p> <p><input type="checkbox"/> History of headaches</p> <p><input type="checkbox"/> History of migraines</p> <p><input type="checkbox"/> Vision problems</p> <p><input type="checkbox"/> Vision loss</p> <p><input type="checkbox"/> Ear problems</p> <p><input type="checkbox"/> Hearing loss</p> <p>Women</p> <p><input type="checkbox"/> Pregnant, due: _____</p> <p><input type="checkbox"/> Gynaecological conditions, what? _____</p> <p>Overall, how is your general health? _____</p> <p>Primary Care Physician: _____</p> <p>Address: _____</p> <p>_____</p> <p>_____</p>
<p>Current Medications: _____</p> <p>condition it treats: _____</p> <p>Are you currently receiving treatment from another health care professional? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>If yes, for what? _____</p> <p>Surgery – date _____</p> <p>Nature: _____</p> <p>Injury – date _____</p> <p>Nature: _____</p>		<p>Do you have any other medical conditions? (e.g. digestive conditions, haemophilia, osteoporosis, mental illness) <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Do you have any internal pins, wires, artificial joints or special equipment? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>What? _____</p> <p>Where? _____</p> <p>What is the reason you are seeking massage therapy? Please include the location of any tissue or joint discomfort. _____</p> <p>_____</p> <p>_____</p>

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Consent to Treatment

It is my choice to receive massage therapy. I realize that the treatment is being given for the well being of my body and mind. This includes stress reduction, relief from muscular tension, spasm or pain, or for increasing circulation. I agree to communicate with my practitioner, and at any time during treatment I have the right to refuse any or all parts of the treatment now or at anytime in the future. At any time if I feel uncomfortable with the procedures, techniques or area being treated I may tell the therapist and the procedure will be stopped or modified.

I understand that massage therapists do not diagnose illness, disease or any physical mental disorders; nor do they prescribe medical treatments, drugs, or perform spinal manipulations. I acknowledge that a massage is not a substitute for a medical examination or diagnosis and that it is recommended that I see a primary healthcare provider for that service.

I have stated all medical conditions that I am aware of, and will update the massage therapist of any changes in my health status.

Signature: _____

Date: _____