Health History Form

Meagan Michalski, RMT & Kaitlyn Hough, RMT

An accurate health history is important to ensure that it is safe for you to receive a massage treatment. If your health status changes in the future, please inform you therapist. All information gathered for this treatment is confidential except as required or allowed by law or except to facilitate diagnosis (assessment) or treatment. You will be asked to provide written authorization for release of any information.

PERSONAL INFORMATION

Name: ______________________________
Address: ______________________________
City: ______________ Postal Code: ________
Who referred you? ______________________
Primary Physician: ______________________
Physician Phone Number: ________________

Today's Date: ______________________
Birthdate: ______________________
Phone Number: ______________________
Business Number: ______________________
E-Mail: ______________________
Emergency Contact: ______________________
Emergency Contact #: ______________________

Other Health Care Practitioners: Chiropractor Physiotherapist Naturopath Other: __________
General Health Status: POOR FAIR GOOD EXCELLENT
Occupation: ______________________ Recreational Activities: ______________________
Primary Occupation Activities: ______________________________________
Primary Complaint: ______________________________________
Pain Scale: 0 1 2 3 4 5 6 7 8 9 10

HEALTH HISTORY

☑ Please indicate all current/ongoing (C/O) and past conditions you have experienced

Head/Neck	**C/O**	**Past**	**Respiratory/Lungs**	**C/O**	**Past**	**Digestive**	**C/O**	**Past**
Whiplash	☐	☐	Asthma	☐	☐	Constipation	☐	☐
Headaches	☐	☐	Bronchitis	☐	☐	Diarrhea	☐	☐
Migraine	☐	☐	Emphysema	☐	☐	Crohn's Disease	☐	☐
Concussion	☐	☐	Pneumonia	☐	☐	Irritable Bowel Syndrome	☐	☐
Ringing in the Ears	☐	☐	Shortness of Breath	☐	☐	Ulcers	☐	☐
Hearing Loss	☐	☐	Sinusitis	☐	☐	Diverticulitis	☐	☐
Vision Problems	☐	☐	Frequent Colds	☐	☐	Nausea	☐	☐
Brain Injury	☐	☐	Recurrent Lung Infection	☐	☐			
TMJ (Jaw Pain)	☐	☐	Chronic Cough	☐	☐			

Other: ______________________
Family History of Above: __________
Other: ______________________
Other: ______________________

Cardiovascular	**C/O**	**Past**	**Nervous System**	**C/O**	**Past**	**Infections**	**C/O**	**Past**
High Blood Pressure ____/_____	☐	☐	Spinal Cord Injury	☐	☐	Hepatitis	☐	☐
Low Blood Pressure ____/_____	☐	☐	Numbness/Tingling	☐	☐	Type: __________		
Heart Attack	☐	☐	Sensory Change/Loss	☐	☐	Infectious Skin	☐	☐
Chronic Congestive Heart Failure	☐	☐	Sciatica	☐	☐	Conditions	☐	☐
Chest Pain/Angina	☐	☐	TOS	☐	☐	TB	☐	☐
Stroke	☐	☐	Seizures	☐	☐	HIV	☐	☐
Pace Maker or Similar Device	☐	☐	Multiple Sclerosis	☐	☐			
Phlebitis	☐	☐	Cerebral Palsy	☐	☐			
Hemophilia	☐	☐	Epilepsy	☐	☐			
Heart Disease	☐	☐	Carpal Tunnel	☐	☐			
Poor Circulation	☐	☐	Muscular Dystrophy	☐	☐			
Congestive Heart Failure	☐	☐						

Family History of Above: ______________
Other: ______________________
Other: ______________________
Other: ______________________

Disease/Condition	C/O	Past
Cancer Benign/Malignant	☐	☐
Type/Location: ________________________		
Treatment: ____________________________		
Fibromyalgia	☐	☐
Chronic Fatigue Syndrome	☐	☐
Allergies	☐	☐
Diabetes (Type?) _____________		
Onset: ________________________________		
Other: ________________________________		

Skin	C/O	Past
Eczema	☐	☐
Dermatitis	☐	☐
Acne	☐	☐
Frostbite	☐	☐
Psoriasis	☐	☐
Sensitive Skin	☐	☐
Rash/Eruptions	☐	☐
Cold Sores	☐	☐
Herpes	☐	☐
Other: _______________________		

Bone/Joint	C/O	Past
Dislocation	☐	☐
Fracture	☐	☐
Arthritis (RA/OA)	☐	☐
Family History of Arthritis: _____________		
Degenerative Disc Disease	☐	☐
Prolapsed/Herniated Disc	☐	☐
Other: ________________________________		

Soft Tissue Joint Discomfort or Pain	C/O	Past
Head/Jaw	☐	☐
Neck	☐	☐
Shoulder	☐	☐
Arm	☐	☐
Wrist/Hand	☐	☐
Back	☐	☐
Hips	☐	☐
Legs	☐	☐
Knees	☐	☐
Ankles/Feet	☐	☐
Tendonitis	☐	☐
Strain/Sprain	☐	☐
Poor Posture	☐	☐
Other: ____________________________________		

Women Only	C/O	Past
Pregnancy	☐	☐
Vaginal Birth/Abortion	☐	☐

Weeks Pregnant: ________________

# of Children (not including this pregnancy) _____________

Therapist Notes:

Current medication or supplements and what condition do your medicine/supplements treat: ________________________________

____

Surgical operations or Hospitalizations (please indicate date of occurrence): ________________________________

____

Major injuries/accidents including fractures (please indicate date of occurrence): ________________________________

____

Of special note: (pins, wires, plates, artificial joints, etc.) Please explain: ________________________________

____

List any areas that you do **NOT** want treated: ____

Are you physically active?	Yes ☐	No ☐

How often and Type? __________________________

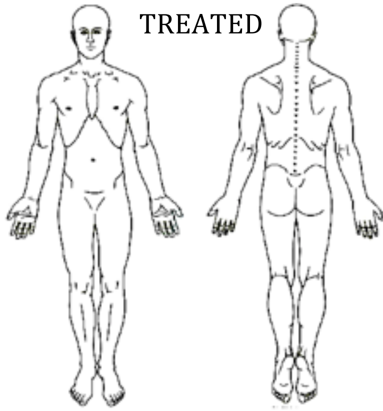
Previous Massage Experience	Yes ☐	No ☐	
Good Sleeping Habits	Yes ☐	No ☐	
Regular Eating Habits	Yes ☐	No ☐	
Stress Levels	High ☐	Medium☐	Low ☐

Date: ____

Client Signature: ____________________________________

Therapist Signature: __________________________________

PLEASE CIRCLE CURRENT SYMPTOMATIC AREAS YOU WANT TREATED



Client Contract and Informed Consent

Meagan Michalski, RMT & Kaitlyn Hough, RMT

The following is a contract that you, the client is asked to sign as an informed consent. The contract is for you to fully understand your rights for the treatment and responsibility as a client.

It is important for you to let your therapist know of any changes to your health history, so that it may be updated. It is your right as the client to terminate the massage treatment at any time if you feel it is necessary. The therapist also has the right to terminate the massage treatment at any time.

During your massage treatment the therapist will only be undraping one body part at a time, that of which will be that body part that will be worked on. If at any time the therapist feels that Massage Therapy treatment will be beneficial on an area of sensitivity (i.e. Gluteal), the therapist will ask for specific and separate consent before proceeding.

Please list any sensitivities you may have that will affect your massage (i.e. scents, positions, lotions, ect.)
____

There will be a $50 charge for any missed appointments (without a 24hr notice of cancellation) and a $20 charge for any NSF cheques. The missed appointment fee **cannot** be billed to your insurance company. __________ (Initials)

I ______________________________________ have read and fully understood the contract set out and give my consent for a treatment by Meagan Michalski, RMT and/or Kaitlyn Hough, RMT for massage therapy.

Additional consent for Assessment and Treatment of Sensitive areas:
The following applies to areas considered sensitive by the CMTO. Treatment of these areas requires written consent.
I have been informed of and have understood the reason(s) for receiving massage to my

______ buttock(s) (gluteal muscles) (i.e. hip pain, sciatic symptoms, low back pain)
______ inner thigh(s) (i.e. groin pull/injury)
______ chest wall muscles (i.e. pec strain, chest/rib pain/injury)
______ breast tissue (Individual basis, this will be disused at length with RMT)

For any of the above areas that I have checked off and initialed, I have been informed of the reasons, the benefits, risks, and side effects, and the proposed draping (covering). In addition, I have had all of my questions regarding this treatment answered by Meagan Michalski, RMT

I ______________________________________ have read and fully understood the contract set out and give my consent for a treatment by Meagan Michalski, RMT and/or Kaitlyn Hough, RMT for massage therapy.

Additional consent for Motor Vehicle Accident clients:
If you have any extended health care benefits, please let Meagan Michalski, RMT and/or Kaitlyn Hough, RMT know during the first appointment. Any funds available through an extended health care benefits plan **must** be exhausted first before invoicing the auto insurer for any treatments.

Any treatments that are not covered by either your extended health care benefits plan or your auto insurance (i.e. if you have exhausted funds from both parties), it will be the sole responsibility of you, the client, to cover the cost of any treatments that are not covered.

I ______________________________________ have read and fully understood the above bullets and give my consent for a treatment by Meagan Michalski, RMT and/or Kaitlyn Hough, RMT for massage therapy.

__________________________________ __________________
Signature: Date:

__________________________________ __________________
Therapist Signature: Date:

Referral Information

How did you hear about my practice?? (Please indicate all that apply) I would like to thank them for referring you to my practice. This sheet is to be voluntarily filled out.

Personal Referrals

Friend: ______________________________________

Colleague: ___________________________________

Family Member: ______________________________

Medical Referrals

Medical Doctor: ______________________________

Chiropractor: _________________________________

Physiotherapist: _______________________________

Massage Therapist: ___________________________

Acupuncturist: ________________________________

Other Health Professional: ____________________

____

Other Referral Points

Gift Certificate (Received)

Gift Certificate (Won)

Gardenia Salon and Spa

Woodstock YMCA

Yellow Pages Book

Other ___________________________

(Name/place of referral)

Online/Social Media Referrals

Facebook

Twitter

woodstocknaturopath.ca

YellowPages.ca

cmto.ca (Find an RMT)

rmtao.ca (RMT find)

Other: __________________________

(Name of website)