Natural Touch Sports & Injury Massage

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(403) 922-2997 www.naturaltouchmassage.ca

Health History for Massage Therapy

Please take a moment to fill out this health history form as completely as possible. The information gathered through your health history provides your massage therapist with necessary information to treat you safely. Please feel free to ask questions about why we are requesting this information. The information you provide us with will be kept confidential unless you submit a written request for us to release your information or if required by law.

First Name: _____ Date:_____
Last Name:_____ Occupation:_____
Date of birth: _____
DD/MM/YEAR

Contact Information:
Street Address:_____
City:_____ Prov: _____ Home Phone:_____
Postal Code:_____ Cell Phone:_____
Email:_____ Work Phone:_____
Emergency Contact (Name):_____ Call me first at: ☐ Home ☐ Cell ☐ Work
Emergency Phone: _____ Allergies:_____
Medications: _____
Family Physician: _____ _____
Chiropractor:_____ Activities:_____
Physiotherapist:_____ _____

How did you hear about our office? (circle one): Internet Sign Location Referral:_____

Have you received massage therapy before? □No □Yes If yes, how have you responded to massage therapy in the past? _____

Were you referred for massage therapy from a healthcare practitioner? □No □Yes If yes, please provide their name and clinic:_____

What is your primary complaint? _____
_____

Can you describe it? (circle all that apply) DULL SHARP SHOOTING ACHY NUMB TINGLING STIFF

Pain scale: (Low) 1 2 3 4 5 6 7 8 9 10 (High) Does the pain radiate anywhere?_____

Does anything aggravate your symptoms? _____
_____

Does anything relieve your symptoms? _____
_____

Do you know what caused this problem? _____

When did it start? _____

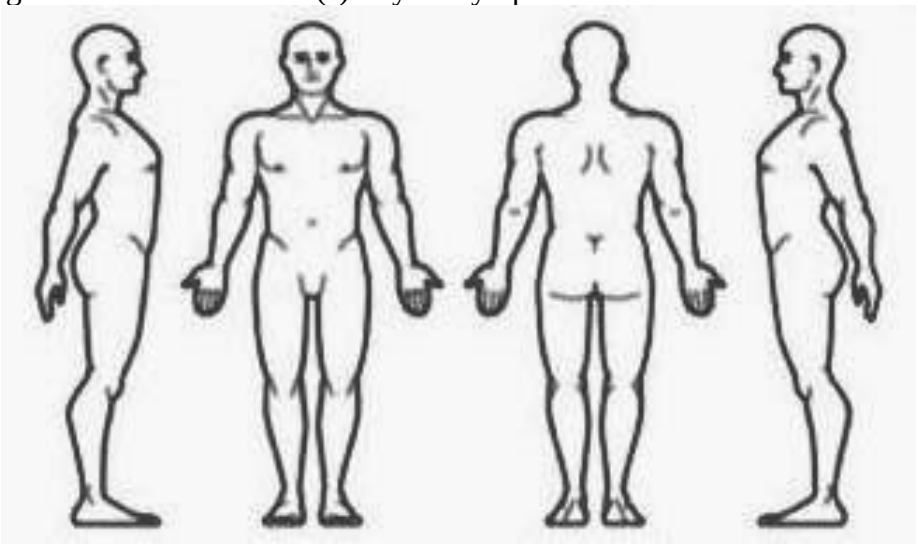
When do you experience the pain? (ie. Sleep, Morning, After Activity) _____
_____

How long does it last? _____

Is this condition interfering with (circle all that apply) WORK SLEEP DAILY ROUTINE ACTIVITIES

Have you had any other injuries, surgeries or car accidents? If so, please describe and give date(s):_____
_____
_____

Please indicate on the diagram below the location(s) of your symptoms:



Check all that apply:

General
- □ Allergies
- □ Anxiety
- □ Bruise easily
- □ Cancer
- □ Crunching/Grinding
- □ Depression
- □ Diabetes
- □ Dizziness/Fainting
- □ Epilepsy
- □ Fatigue
- □ Fibromyalgia
- □ Multiple Sclerosis
- □ Mental stress
- □ Nervousness
- □ Numbness/Tingling
- □ Sleep disturbances
- □ Thyroid disease
- □ Tremors
- □ Ulcers
- □ Weight loss/gain

Infections
- □ Hepatitis
- □ Skin conditions/rash
- □ TB
- □ HIV/AIDS
- □ Herpes

Gastrointestinal
- □ Abdominal pain
- □ Colitis/Crohn's
- □ Constipation
- □ Diarrhea
- □ Digestive conditions
- □ Indigestion/heartburn
- □ Bloated abdomen
- □ Hernia
- □ Nausea
- □ Pain over stomach
- □ Poor appetite
- □ Vomiting
- □ Other_____

Head/Neck
- □ Headaches/Migraines
- □ Jaw pain
- □ Vision problems
- □ Ear problems
- □ Ringing in the ears

Women only
- □ Pregnant? Due_____
- □ Gynaecological issues? What_____ _____

Cardiovascular
- □ High blood pressure
- □ Low blood pressure
- □ Congestive heart failure
- □ Palpitations
- □ Poor circulation
- □ Rapid heart beat
- □ Slow heart beat
- □ Swelling of ankles
- □ Pacemaker
- □ Heart attack/disease
- □ Phlebitis/varicose veins
- □ Stroke/TIA

Respiratory
- □ Chest pain
- □ Chronic cough
- □ Difficulty breathing
- □ Hay fever
- □ Shortness of breath
- □ Bronchitis
- □ Asthma
- □ Wheezing
- □ Pneumonia
- □ COPD/Emphysema
- □ Smoker?

Soft Tissue/Joint Pain
- □ Arthritis/Rheumatism
- □ Bursitis
- □ Muscle weakness
- □ Pins/plates/wires
- □ Fractures
- □ Low back pain
- □ Neck pain
- □ Mid back/shoulder pain
- □ Hip pain
- □ Arms/hand pain
- □ Leg pain
- □ Knee pain
- □ Foot pain
- □ Joint pain
- □ Bone pain
- □ Osteoporosis

Other _____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____

Energy levels: □ Low □ Average □ High
Do you feel stressed? □ No □ Yes Cause?_____
Regular exercise? □ No □ Yes Type_____ Frequency _____
Regular sleep habits? □ No □ Yes
Computer use? □ No □ Yes How many hours/day? _____ How many monitors? _____

Which one of the following statements most closely describes the reason why you are seeking massage therapy (please check which box(es) apply):

□ I want to get better as fast as possible and get back to my life
□ I have some ongoing/reocurring aches and pains and massage is part of my self maintenance/care routine
□ I just really need to relax. Life can be hard and stressful and massage therapy gives me relief

Have you received a diagnosis from your doctor for this condition? (Circle one) No Yes
If yes, please describe to the best of your knowledge what the diagnosis is and indicate approximately when you were diagnosed: _____
_____

What is your understanding of your condition and how it is affecting you? _____
_____
_____

Are you receiving treatment from any other health care practitioners? (Circle one)
Chiropractor Medical Doctor Naturopath Massage Therapist Physiotherapist Acupuncturist TCM
Other _____ Is your current treatment helping? No Yes

What are your goals for this session and any future sessions? _____
_____
_____
_____

INFORMED CONSENT TO MASSAGE THERAPY TREATMENT

I understand that the Registered Massage Therapist is providing massage therapy services within their scope of practice as defined by their association.

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 disorders. 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 with any treatment there can be risks and those risks have been explained to me and I assume those risks.

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.

Client Name: _____ Signature of Client/Guardian: _____

Therapist Name: _____ Date Signed: _____