HEALTH HISTORY FORM

Name: _____ Telephone: (home) _____
(work) _____

_____ _____ _____
Address City Postal Code

Date of Birth: ____ / ____ / ____ E-Mail: _____
Day Month Year

Occupation: _____ Referred by _____

Extended Health Care / Group Insurance for Massage? ☐ Yes ☐ No

Name of Doctor _____ Telephone _____

Address of Doctor _____

Name of Chiropractor _____

List other therapies _____

Current Medications & Condition Treating: _____

_____

_____

Please list all past surgeries with approximate date _____

_____

Please list the presence of internal pins, wires, plates, artificial joints or special equipment. _____

_____

What is your primary complaint? (main concern) _____

_____

Note: 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 let me know.

Is this a Workplace Safety Claim? Yes ☐ No ☐ If yes, please answer the following:
Date of Injury _____ SIN# _____ Claim # _____
Date of Accident Report _____ Have you seen a doctor? Yes ☐ No ☐
How did the accident occur? _____

_____

Have you ever been involved in a motor vehicle accident? Yes ☐ No ☐ When? _____

Is this a no fault insurance claim? Yes ☐ No ☐ **If yes** please answer the following:
Name & Address of Insurance Company _____

_____

Policy # _____ Claim # _____
Brief description of accident _____

_____

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HEALTH HISTORY FORM

Respiratory

- ❒ Chronic cough
- ❒ Shortness of breath
- ❒ Asthma
- ❒ Bronchitis
- ❒ Emphysema

Affected Joints

- ❒ Jaw
- ❒ Neck
- ❒ Shoulder
- ❒ Elbow
- ❒ Wrist
- ❒ Hand
- ❒ Back pain
  - upper ☐
  - middle ☐
  - lower ☐
- ❒ Hip
- ❒ Knee
- ❒ Ankle
- ❒ Foot
- ❒ Pain
- ❒ Stiffness
- ❒ Swelling
- ❒ Limited motion
- ❒ Fatigue
- ❒ Tingling / numbness
- ❒ Fractures
- ❒ Tendonitis/ bursitis
- ❒ Sprain / strain
- ❒ Cramping
- ❒ Spasms

Infectious Disease

- ❒ Hepatitis
- ❒ TB
- ❒ HIV
- ❒ Skin conditions

Digestive

- ❒ Constipation
- ❒ Gas / Bloating
- ❒ Nausea
- ❒ Difficult digestion
- ❒ Poor appetite

Other _____

_____

_____

Cardiovascular

- ❒ High blood pressure
- ❒ Low blood pressure
- ❒ Poor circulation
- ❒ Chronic congestive heart failure
- ❒ Heart attack
- ❒ Stroke / CVA
- ❒ Phlebitis
- ❒ Pacemaker or similar device

Other _____

_____

_____

Skin

- ❒ Allergies
- ❒ Rashes
- ❒ Warts
- ❒ Athletes foot
- ❒ Eczema/psoriasis
- ❒ Other _____

_____

_____

Other

- ❒ Cancer
- ❒ Diabetes
- ❒ Epilepsy
- ❒ Arthritis
- ❒ Stress
- ❒ Headaches

Type _____

_____

- ❒ Allergies to:

_____

_____

_____

_____

_____

- ❒ Sinus
- ❒ Vision loss
- ❒ Hearing loss
- ❒ Depression
- ❒ Loss of sleep

Woman

- ❒ Pregnant
  - ❒ Yes ❒ No

How Long? _____

_____

- ❒ PMS
- ❒ Menopause
- ❒ Painful menstruation

HEALTH HISTORY FORM

What are your goals for receiving massage therapy? _____

_____

What area(s) of your body do you want to focus therapy on? _____

Are there areas that you prefer not to have treated? _____

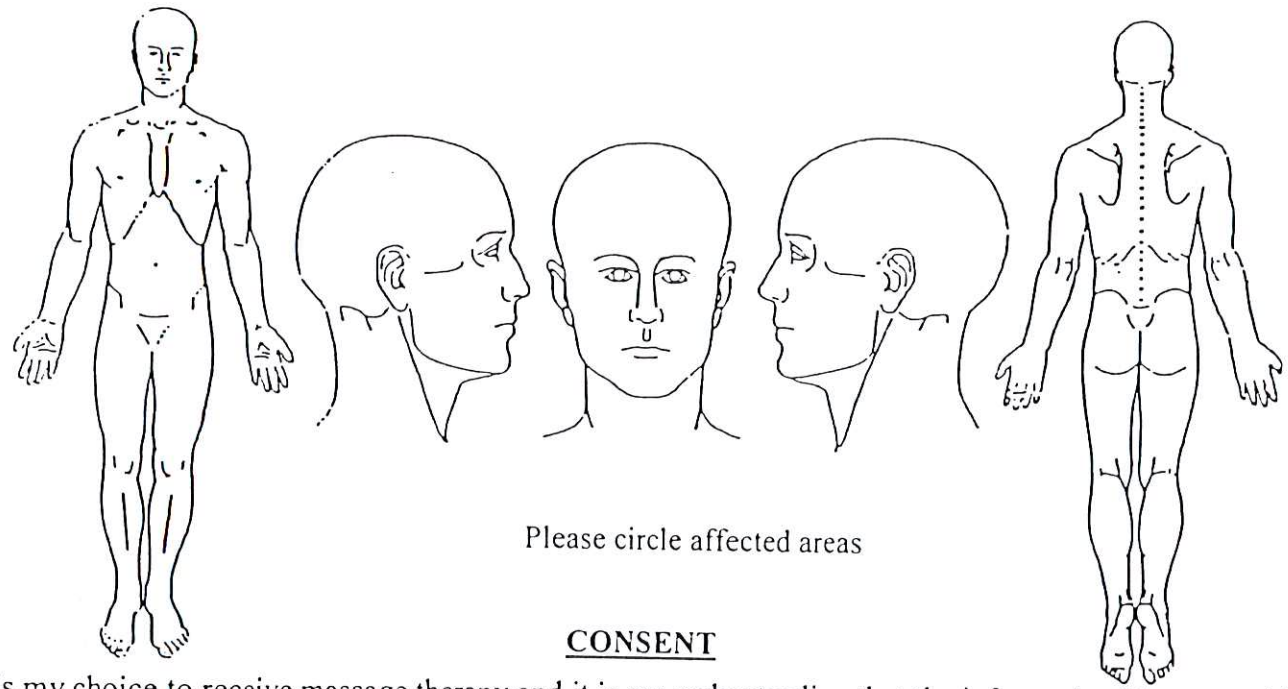
Posture assumed throughout the day: _____

Have you had x-rays before? Yes☐ No ☐ If yes, what areas?

List recreation or sporting activities:

Have you ever received a professional massage? Yes ☐ No ☐

Regular Sleeping habits Yes ☐ No ☐
Regular exercise Yes ☐ No ☐



Please circle affected areas

CONSENT

- It is my choice to receive massage therapy and it is my understanding that the information I have provided is confidential except as required or allowed by law or to help facilitate treatment. You will be asked to provide written authorization for release of any information.
- I agree to communicate with my massage therapist anytime I feel that my well-being is compromised, and I acknowledge that I may terminate the treatment at any point without reason.
- I am aware that it is not necessary to remove all articles of clothing for treatment, and I will remove the clothing I am comfortable with.
- I am aware that I may experience possible side effects from the massage treatments such as temporary muscle discomfort (24-48 post treatment), bruising, headache or dizziness.
- Payment is expected as service is rendered unless prior financial arrangements have been made. An appointment may be cancelled without charge by giving 24 hours notice.
- The following charges will be in effect if no notice of cancellation is given: $ 30.00 for 1 hour treatment; $15.00 for ½ hour treatment

Signature _____ Date: _____

Your Personal Information, the PIPED Act, and Your Therapist

The Personal Information Protection and Electronic Documents Act is a federal act that comes into force January 1st, 2004. It requires any business or group (non-profit or otherwise) that performs "commercial transactions" (buying, or selling) to take responsibility for the personal information they collect.

Personal information is defined as anything other than the sort of information that appears on a business card or in a phone book. This would include credit card information, dates of appointments, buying preferences, records of past purchases, health information, and any other information that can be connected with a person.

In addition, the PIPED Act gives people more clearly defined rights to control their personal information.

What does this mean to you?

Under the new act, you have new rights:

1. You have the right to see any personal information collected about you.
2. Businesses must inform you of what information is collected, why it is being collected, used or disclosed, how long it will be kept, who will be able to see it, and have any of your personal information.
3. You have the right to request a correction to any of your personal information.
4. You have a process available through the Privacy Commissioner of Canada if our response is not satisfactory.

What happens now?

The first step is providing you with this information sheet. It will inform you of what information we collect, why we collect that information, how long we keep it, how we protect it, who may see it and why we release information.

Next, we will ask you to sign a consent form. This form will give us permission to collect that information, share it as appropriate, and will confirm that w have your information correct. Each year we will check with you to see if anything has changed and have you sign again confirming that the information we have is correct.

If you have any questions about the PIPED Act, the information we collect, our policies with regards to privacy, or any other privacy concerns, please do not hesitate to speak with **MARIO LOMBARDI** who is the privacy officer for **THIS OFFICE.**

RMT Privacy Consent Form

I am aware that THIS OFFICE is keeping personal information as outlined on the reverse of this page for the reasons disclosed. I am aware that the members of this staff of THIS OFFICE may access this information. I give my consent for this information to be collected and disclosed as outlined to me.

_____ My file may be used for Quality Audit purposes.

_____ You may consult other healthcare professionals about my case.

_____ The office staff may look up pertinent information for rescheduling purposes and or as deemed necessary.

Your privacy is our utmost concern.

Name: _____ Signature: _____

Date: _____

If parent or Guardian is signing:

Name: _____ Signature: _____

Relationship: _____ Date: _____

I have reviewed my information with the office and accept that it is substantially accurate.

Date: _____ Signature: _____