georgian family
—CHIROPRACTIC—

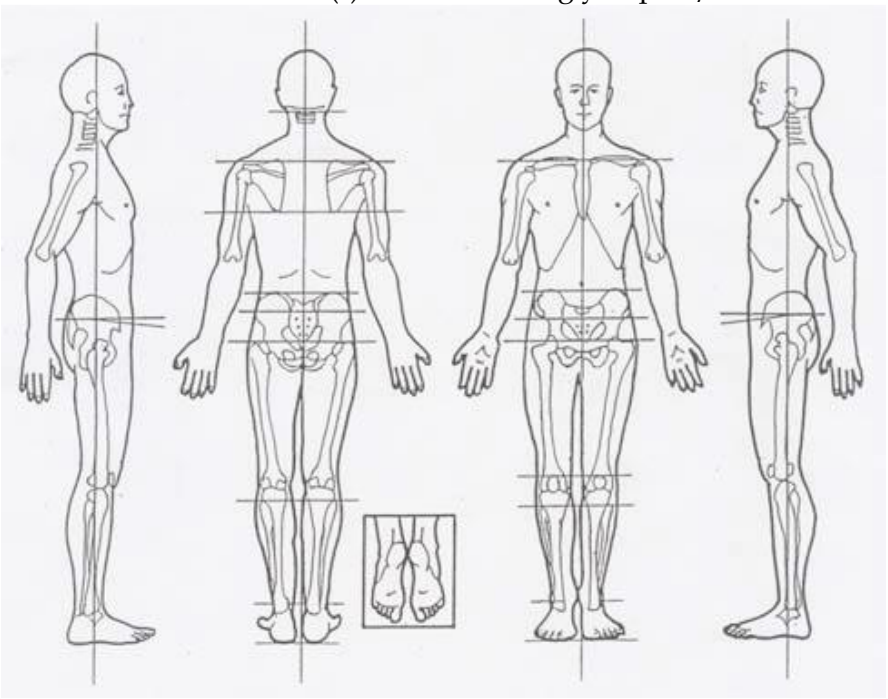
801 River Rd. W.
Wasaga Beach, ON. L9Z 2N7
Phone – (705) 422-1221
Fax – (705) 422-1228

Registered Massage Therapy 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: _____ **Phone:** _____
Address:_____
Date of Birth: _____ **Occupation:** _____
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:
_____
_____
Primary care physician: _____

Please indicate the area(s) that are causing you pain/discomfort:



What is the reason you are seeking massage therapy?
_____
_____

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On a scale of 1-10 (1 being very little pain/ discomfort, 10 being the most) where would you rate your discomfort/ pain? _____

Is there anything that alleviates the pain/discomfort? _____

Is there anything that makes the pain/discomfort worse? _____

Is your pain/discomfort making daily activities hard to complete? If so, please include which activities are being compromised.

_____

_____

What would you like to focus on during your massage treatment? _____

_____

Please X any conditions you are experiencing and circle any conditions you have experienced previously:

Cardiovascular

High blood pressure
Low blood pressure
Chronic congestive heart failure
Heart attack
Phlebitis/varicose veins
Stroke/CVA
Pacemaker/similar device
Other: _____

Is there a family history of the above?
Yes No

Respiratory

Chronic cough
Shortness of breath
Bronchitis
Asthma

Emphysema
Other: _____
Is there a family history of the above?
Yes No

Infection

Hepatitis
Skin conditions
TB
HIV
Herpes

Head/neck

History of headaches
History of migraines
Vision problems
Vision loss

Ear problems
Hearing loss

Women

Pregnancy
Due: _____

Gynaecological concerns
Type? _____

Other Conditions

Loss of sensation
Where? _____
Diabetes
Onset? _____
Allergies/hypersensitivities
Type? _____
Cancer
Type? _____
Skin conditions
Type? _____
Digestive conditions
Type? _____
Mental illness
Type? _____
Osteoperosis

Overall health?

Medications:
_____

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Consent for Massage Therapy Assessment/ Re-Assessment, Treatment Plan and Treatment

Note to client: *We want your informed consent. That means that we want you to understand the services we hope to provide you, the cost involved, and what we do with personal information we obtain about you. If you have any questions on any of this please ask.*

Massage Therapy is the manipulation of the soft tissues of the body through manual techniques.

To deliver a better treatment and resolve the problem more quickly, an assessment/re-assessment of the client will need to be completed. The assessment allows the Massage Therapist to better identify the structures causing the Client discomfort and allows for a more comprehensive treatment plan and treatment. As the Client, you are free to stop or modify the assessment at an time, the Massage Therapist will be checking in periodically on your comfort level during the assessment/ re-assessment. This assessment can include, but is not limited to, specific testing that will help to rule out or in a specific condition, range of motion, muscle testing, reflex testing and blood pressure. Depending on the condition and the associated assessment/ re-assessment, the purpose of the assessment, the areas and actions of the client, complications/risks, and the findings of the assessment will be discussed in greater detail as needed. Questions are encouraged at any time during this process. Residual pain and exacerbation of the condition is a possibility with assessment/ reassessment. Gathering information from an accurate and up to date health history, assessment/ re-assessment, and client outcomes from the treatment plan allow the therapist to put together a treatment that will be most beneficial for the client.

I give my consent for the RMT to complete an assessment/ re-assessment

_____

A treatment plan includes the client's functional and treatment goals, the type of treatment, the areas of the body that will be treated, the frequency and duration of the treatment, anticipated response from the client, any remedial exercises or homecare needed, and the schedule for reassessment. All of these will be included in your client file.

I give my consent for the RMT to complete and keep a treatment plan

_____

The nature of a massage treatment is determined by both the Client and the Massage Therapist and is subject to change depending on the specific client and condition. The assessment/ re-assessment and treatment plan completed as well as the accurate and up to date health history help to determine this nature. The nature of the massage will be discussed along with cautions and contraindications, benefits of massage, risks and complications, consequences of not completing the treatment, and alternatives to massage prior to the first treatment as well as with changes to the client/condition. The Massage therapist will check in periodically during treatment(s) on the Client's comfort level and the Client is free to stop or modify the massage at any time. After receiving treatment the client could feel light headed from lying on the table for extended periods of time, residual discomfort from deep tissue work, etc.

I give my consent for the RMT to complete treatment

_____