REGISTERED MASSAGE THERAPY

Confidential Health History Form

sage Health and Wellness

12 Irwin Ave Suite 200-201, Toronto, ON M4Y 1K9

The information on this form is confidential and will be used to assist your therapist in determining your treatment plan.

Name: _____ Home #: _____

Address: _____ Cell #: _____

City/Province: _____ Work #: _____

Postal Code: _____ Email: _____

❑ **YES! it is okay to send periodic e-mails**

Height:_____ **Weight:**_____

Occupation: _____

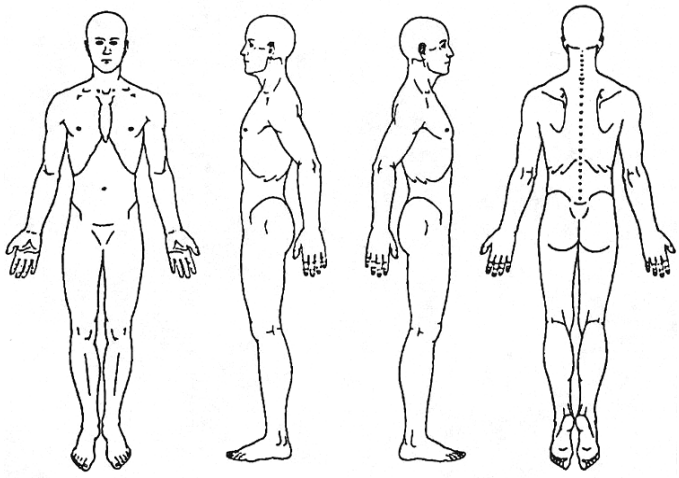
Date of Birth _____/___/_____ **Who can we thank for this referral?** _____

DD/MM/YY

Do you have benefits? ❑ YES! ❑ No

What brings you in for massage today? _____

Indicate where you feel you pain and or check areas to the right



● – muscle pain **√** – numbness/tingling

+ – joint pain **X** – general pain

What is your chief complaint?_____

How long have you had it?_____

When is the pain worse/better?_____

Soft Tissue/Joint Discomfort Describe:

- ❑ Neck_____
- ❑ Shoulders _____
- ❑ Upper back _____
- ❑ Mid back _____
- ❑ Low back _____
- ❑ Arms _____
- ❑ Wrists_____
- ❑ Legs _____
- ❑ Knees _____
- ❑ Other:

Primary Care Physician: _____

Address & Phone:_____

Exercise / Physical Activity:_____

_____

Frequency:_____

Medications/ Supplements	Reason for Taking
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

HEALTH HISTORY: Please indicate conditions you are experiencing, or have experienced in the past:

Please include all information whether you feel it's relevant or not – Remember our muscles hold memories!

General
- ❑ Allergies

Describe:_____
- ❑ Cancer – Type:_____
- ❑ Diabetes – Type:_____
- ❑ Epilepsy – Type:_____
- ❑ Fainting / Dizziness
- ❑ Fatigue / Loss of Sleep
- ❑ Fever / Sweats
- ❑ Numbness/Tingling/ Loss of Sensation

Respiratory
- ❑ Chronic Cough
- ❑ Chest Pain
- ❑ Shortness of Breath
- ❑ Bronchitis / Pneumonia
- ❑ Asthma
- ❑ Emphysema
- ❑ Smoking: #yrs:_____

Genitourinary
- ❑ Frequent / Painful Urination
- ❑ Kidney / Bladder Infection
- ❑ Urinary Tract Infection
- ❑ Kidney Stones
- ❑ Prostrate Trouble
- ❑ Incontinence

Bone / Arthritis
- ❑ Osteoarthritis
- ❑ Rheumatoid Arthritis
- ❑ Osteoporosis / Osteopenia
- ❑ Gout

Head/Neck
- ❑ Failing Vision
- ❑ Deafness / Hearing Loss / Tinnitus
- ❑ Ear Ache / Ear Discharge
- ❑ Nose Bleeds – Freq._____
- ❑ Nasal Obstruction
- ❑ Sore Throat
- ❑ Gum Trouble / Bleeding
- ❑ Frequent Colds
- ❑ Tonsillitis
- ❑ Sinusitis
- ❑ Jaw Pain / TMJ Dysfunction
- ❑ Headaches / Migraines

Describe:_____

Frequency: Weekly/ Occasionally/ Stress

Skin
- ❑ Eczema/Psorasis Loc:_____
- ❑ Itchy/ Dry Skin / Rash

Location:_____
- ❑ Bruises Easily
- ❑ Sensitive Skin
- ❑ Warts

Location:_____

Infectious Diseases
- ❑ Chicken Pox – When:_____
- ❑ Mumps / Measles
- ❑ Hepatitis A B C
- ❑ TB
- ❑ HIV
- ❑ Infectious Skin Condition

Type:_____
- ❑ Other: _____

Women
- ❑ Pregnant Due Date_____)
- ❑ # of Pregnancy: _____)

Type of Child Birth?_____
- ❑ Miscarriage(s)_____
- ❑ Menstrual Pain
- ❑ Irregular Cycle / Excessive Flow
- ❑ Cramps and or Backache
- ❑ Breast Tenderness / Swelling
- ❑ Lumps in Breasts
- ❑ Menopause / PMS
- ❑ Yeast Infections
- ❑ Fibroids / Cysts

Cardiovascular
- ❑ High Blood Pressure
- ❑ Low Blood Pressure
- ❑ Chronic Congested Heart Failure
- ❑ Heart Attack / Angina
- ❑ Varicose Veins Loc:_____
- ❑ Phlebitis
- ❑ Stroke/CVA
- ❑ Poor Circulation
- ❑ Swelling In Ankles

Gastrointestinal
- ❑ Poor / Large Appetite
- ❑ Difficult Digestion
- ❑ Excessive Belching or Gas
- ❑ Constipation / Diarrhea / IBS
- ❑ Liver / Gallbladder Trouble
- ❑ Acid Reflux / Hiatus Hernia
- ❑ Stomach Pain
- ❑ Hemorrhoids

Present/Past Involvement in Therapies:

❑❑ Massage ❑❑ Chiropractic ❑❑ Physiotherapy ❑❑ Naturopathy ❑❑ Acupuncture ❑❑ Osteopathy ❑❑ Other

_____

Injury: _____ **Date:** _____ **Surgery:** _____ **Date:** _____

Nature: _____ **Nature:** _____

Injury: _____ **Date:** _____ **Surgery**: _____ **Date:** _____

Nature: _____ **Nature:** _____

Other Medical Conditions: (digestive or gynecological conditions, hemophilia. hypophilia, anemia, fibromyalgia, SLE)

_____

Of Special Note: (presence of internal pins, wires, artificial joints, pacemaker/similar device, or special equipment):

_____

Updated _____ Updated _____ Updated _____ Updated _____

THANK-YOU for taking the time to complete this health profile. Please ask your therapist if you have any questions.

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Consent to Treatment Form

12 Irwin Ave Suite 200-201, Toronto, ON M4Y 1K9

Under the Health Care Consent Act, 1996, in accordance with the Massage Therapy Act, 1991, we require your consent prior to commencing any treatments for you.

Please print your full name above and sign and date below, after carefully reading this section;

I, _____ understand the information given in the health history form is confidential and will only be used by the therapist for clinical records. The information will be protected by Sage's Privacy Policy and not be released to anyone without my consent.

I acknowledge that my therapist has provided me with such information as is pertinent to the treatment for my primary complaint. Alternative courses of treatment (where applicable and relevant) have been explained to me, as well as the possible risks and side effects, if any.

I understand I may change my mind regarding any aspect of this treatment at any time and upon informing my therapist of my decision, I may withdraw my consent with the intent to alter or discontinue the treatment.

I acknowledge the following areas may be addressed during the course of a treatment: head, neck, upper chest, arms, back, abdomen, buttocks, legs, hands and feet (breast and groin areas excluded).

I do not wish the following area(s) to be treated:_____

During the treatment I may ask for a change in pressure, increase/decrease in the temperature of the room or the lighting, to my satisfaction. I also have the right to stop treatment at any time if I wish.

I understand I may be charged for the treatment if I do not call to cancel with 24-hour notice. I also understand if I show up late I may not receive my full scheduled time, however I will pay for the appointment I booked.

I feel I fully understand what is involved in the proposed treatment and provide my full voluntary, informed consent to treatment.

_____

Signature

_____

Date