

431 Huronia Road, Unit 6 - Barrie ON, L4N 9B3 | Phone: 705-735-1169 | Fax: 705-252-7833

## **Confidential Health History Form**

Alexandria Ortolan RMT

An accurate health history is important to ensure that it is safe for you to receive a massage treatment. All information gathered for this treatment is confidential except as required or allowed by law. Written authorization will be required for release of any information.

In the event you cannot attend your scheduled appointment, please allow 24 hrs for cancellation notice. Failure to do so WILL result in a full treatment fee charge.

Date:Name		Gender: M	/ F Age:	Birth Date:
Address:		 City:	Postal	Code:
	Email Address:			
Occupation:	Family Physicia	an:	Phone	e:
Emergency Contact:	Relationship:		Phone:	
	clinic?			
	?			
	Wha			
	wi <mark>th: work? Y</mark> / N Sleep? Y / I			
Do you have any goals for th	e treatment?			
Current Medications & Condi	itions they treat:			
Previous Major Illnesses, Op	erations/ surgeries:			
Previous injuries and date: _				
Other Medical Conditions (e.	g. mood disorders, sleep di <mark>sord</mark> ers	s, <mark>hemo</mark> ph <mark>ilia, dia</mark> beto	es):	
Of special notes: (presence of	of internal pins, wires, artificial join	ts, special equipmen	t):	
Are you currently receiving tr	eatment from another health care	professional? YES	/ NO	
If Yes, who and for what con-	dition:			
Overall, how is your General	Health:	h		
Do you have any concerns a	bout massage otherwise not ment	ioned in this form?		

espiratory	Head/Neck	Skin
Chronic Cough	☐ Headaches/Migraines	Acne
Shortness of Breath	Concussion	☐ Exema
Bronchitis	☐ Vision Problems	Rashes
Asthma	☐ Vision Loss	Athletes
Emphysema	Ear Problems	☐ Warts
] Sinus Infection	☐ Hearing Loss	Other:
ther:	Other:	
there a family history of any of these	Is there a family history of any of these	Soft Tissue/Joint Discomfort (nature)
onditions? YES / NO	conditions? YES / NO	,
		Head
P	0.11	Neck
ardiovascular	Other Conditions	I II ow back
High Blood Pressure	Loss of Sensation	Mid back
Low Blood Pressure	Diabetes (Onset:)	Upper back
Chronic Congestive Heart Failure	Allergies (anaphylaxis or skin irritation)	Shoulders L R
Heart Attack	Epilepsy	I IAIIIS L N
Varicose Veins	Arthritis	□ Elbows L R
Phlebitis	Cancer	☐ Elbows L R ☐ Hand/Wrists L R
Stroke/CVA	Fibromyalgia	
] Stroke/CVA ] Pacemaker or similar device	Urinary Disorders	☐ Legs L R ☐ Knees L R ☐ Foot/Ankle L R
	Urinary Disorders	
Poor Circulation	Kidney Disorders	☐ FOOt/Ankle L R
ther:	_ Digestive Disorders	
there a family history of any of these	Liver	Women
onditions? YES / NO	☐ Hernia	Pregnant (due :)
faction	Other:	Gynecological conditions
fection	Is there a family history of any of these conditions? YES / NO	Menopause (onset)
Infectious skin conditions		
ther: there a family history of any of these onditions? YES / NO		
ther: there a family history of any of these onditions? YES / NO  vill report to the therapist if there are any commander of and this information is true an	understand that all the information I have provid hanges to my health or information necessary for discourate. I hereby authorize the Massage The I will inform my massage therapist of any chang	or the f <mark>orm. I have stated all conditions that l</mark> erapy Program area to use the information a
ther: there a family history of any of these onditions? YES / NO  vill report to the therapist if there are any commander of and this information is true an	hanges to my health or information necessary for discourate. I hereby authorize the Massage The	or the f <mark>orm. I have stated all conditions that</mark> erapy Program area to use the information
ther: there a family history of any of these onditions? YES / NO  vill report to the therapist if there are any commander of and this information is true an	hanges to my health or information necessary for discourate. I hereby authorize the Massage The I will inform my massage therapist of any change	or the f <mark>orm. I have stated all conditions that</mark> erapy Program area to use the information a
ther: there a family history of any of these onditions? YES / NO  vill report to the therapist if there are any community and this information is true an escribed above to facilitate my treatment.	changes to my health or information necessary for d accurate. I hereby authorize the Massage The I will inform my massage therapist of any change Date:	or the f <mark>orm. I have stated all conditions that</mark> erapy Program area to use the information a
ther:there a family history of any of these onditions? YES / NO  ill report to the therapist if there are any come aware of and this information is true an escribed above to facilitate my treatment.	changes to my health or information necessary for d accurate. I hereby authorize the Massage The I will inform my massage therapist of any change Date:	or the f <mark>orm. I have stated all conditions that</mark> erapy Program area to use the information a
ther:there a family history of any of these onditions? YES / NO  fill report to the therapist if there are any common aware of and this information is true an escribed above to facilitate my treatment.  Selient Signature:	changes to my health or information necessary for d accurate. I hereby authorize the Massage The I will inform my massage therapist of any change Date:	or the form. I have stated all conditions that erapy Program area to use the information a ges in my status.
ther:there a family history of any of these anditions? YES / NO  ill report to the therapist if there are any come aware of and this information is true an escribed above to facilitate my treatment.  lient Signature:	changes to my health or information necessary for d accurate. I hereby authorize the Massage The I will inform my massage therapist of any change Date:	or the form. I have stated all conditions that erapy Program area to use the information a ges in my status.