Harmony Health
INTEGRATIVE CENTRE

HEALTH HISTORY AND CONSENT FOR MASSAGE THERAPY

Please take a moment to fill out this health history form as completely as possible. The information gathered provides your massage therapist with necessary information to treat you safely. The information is kept confidential unless you submit a written request for us to release your information or if required by law.

GENERAL CONTACT INFORMATION

Name ____
First name *Last name*

Birthdate (mm-dd-yy): __________________ Gender: _____________ Today's Date (mm-dd-yy): ______________

Address: ____
Street *City* *Province* *Postal Code*

Phone (H): _____________________ (C): _______________________ E-mail: _____________________________

Emergency Contact: ____
Name *Phone Number* *Relationship*

Occupation: _________________________________ How did you hear about the clinic? ______________________

Do you have extended health benefits? Yes No Who may we thank for your referral? ______________________

MASSAGE HISTORY

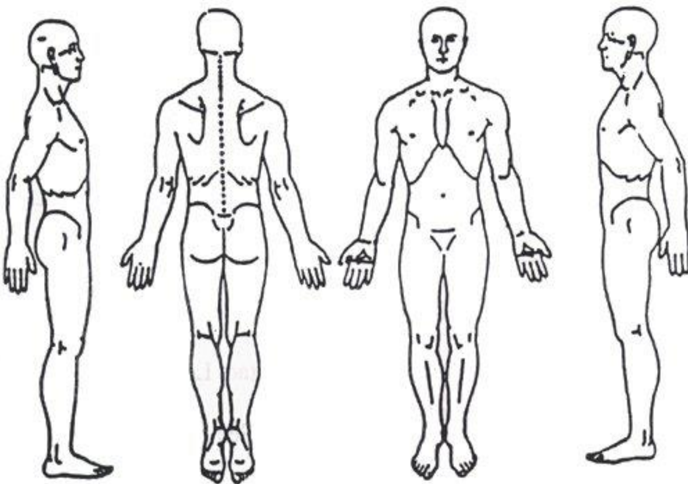
Have you had a therapeutic massage before? Yes / No

Do you have any allergies/sensitivity to oils, essential oils, lotions or ointments? Yes / No If yes, please explain

____

What is the reason for your visit? ____

Circle where you experience your symptoms?



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? ____

When did your symptoms begin? ____

Have they changed? & How? ____

Have you seen any other health care practitioner concerning this complaint? Circle all that apply

Medical Doctor Chiropractor Physiotherapist Acupuncturist Massage therapist

Have you had results? ____

HEALTH HISTORY

Have you experienced any of the following conditions? If so, please indicate which ones:

- ☐ High blood pressure
- ☐ Low blood pressure
- ☐ Congestive heart failure
- ☐ Heart attack
- ☐ Phlebitis/varicose veins
- ☐ Stroke/CVA
- ☐ Pacemaker or similar device
- ☐ Heart disease
- ☐ Atherosclerosis
- ☐ Chronic cough
- ☐ Shortness of breath
- ☐ Bronchitis
- ☐ Asthma
- ☐ Emphysema
- ☐ Smoker
- ☐ History of headaches
- ☐ History of migraines
- ☐ Vision problems
- ☐ Vision loss
- ☐ Ear problems
- ☐ TMJ
- ☐ Tinnitus
- ☐ Accidents
- ☐ Surgeries
- ☐ Injuries
- ☐ Indigestion/heartburn
- ☐ Constipation
- ☐ Hepatitis
- ☐ Skin conditions/rash
- ☐ TB
- ☐ HIV
- ☐ Herpes
- ☐ Open sores/wounds
- ☐ Loss of sensation
- ☐ Diabetes.
- ☐ Allergies.
- ☐ Epilepsy
- ☐ Cancer
- ☐ Fibromyalgia
- ☐ Swelling in the ankles
- ☐ Bruise easily
- ☐ Arthritis
- ☐ Hemophilia
- ☐ Osteoporosis
- ☐ Mental illness/ Trauma
- ☐ Dizziness/fainting
- ☐ Scoliosis
- ☐ Autoimmune Disorder (Lupus, MS, RA etc.)
- ☐ Swollen glands
- ☐ Currently Pregnant

Please list any medication or pain killers you are taking and what condition they are for

____

____

Do you have any internal pins/wires/artificial joints? ____

How would you rate your overall health? (Circle) Fair Good Excellent

LIFESTYLE

Do you feel stressed? Y / N Source of Stress: ____

Regular Exercise? Y / N Type ________________________ Frequency _________________________________

Regular sleep habits? Y / N

Computer use? Y / N How many hours per day (on average)? ____

Is there anything you feel would be important for your massage therapist to know in order to plan a safe and effective massage treatment for you?

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Thank you for completing this intake form.

Informed Consent to Massage Therapy Treatment

I understand that the Candace Hannah, RMT is providing massage therapy services within their scope of practice.

I hereby consent for Candace Hannah, RMT to treat me with massage therapy for the previously noted purposes including such assessments, examinations and techniques, which may be recommended, by Candace Hannah.

I acknowledge that Candace Hannah, RMT is not a physician and does not diagnose illness or disease or any other physical or mental disorder. I clearly understand that massage therapy is not a substitute for a medical examination. It is recommended that I visit my personal physician for any ailments that I may be experiencing. I acknowledge that no assurance or guarantee has been provided to me as to the results of the treatment. 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 Candace Hannah must be fully aware of my existing medical conditions. I have completed my medical history form as provided and disclosed to Candace Hannah, RMT all of those medical conditions affecting me. It is my responsibility to keep Candace Hannah, RMT updated on my medical history. The information I have provided is true and complete to the best of my knowledge.

I understand that all information/conversation exchanged during a treatment session or about a treatment session remains confidential for the safety and well-being of myself and Candace Hannah, RMT.

I understand that if I am late to an appointment, the treatment session will be shortened and I will be charged for the full session. I understand the cancellation policy and that I must provide 24 hours notice of cancellation of an appointment. I understand that I may be charged the full fee for a missed appointment if proper cancellation notification is not provided to the clinic.

I understand that intoxication (any alcohol consumption) during a massage treatment is not permitted. If I attend a treatment session intoxicated, I will be asked to leave and charged the full price for the treatment session. I acknowledge that sexual innuendos, language and/or behavior will not be tolerated. Should this occur, I understand that the Candace Hannah will end the treatment session immediately and I will be charged the full amount for the session.

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 Candace Hannah, RMT 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: ____________________________

Date Signed: ____