



Registered Massage Therapy

541 Palace Road Kingston, ON K7L 4T6
613.547.KIHC (5442)
www.kihc.ca

HEALTH HISTORY FORM

The information requested below will assist us in treating you safely. Please ask any questions about the information being requested. All information provided will remain confidential except where required by law.

Name: _____ Date: _____

Date of birth (dd/mm/yy): _____ Age: _____ Gender: _____

Address: _____

Postal Code: _____

Home Tel: _____ Work Tel: _____ Email address: _____

May we leave telephone messages at home or work? _____

Would you like to receive our complimentary clinic email newsletter? _____

Please circle the name of the Massage Therapist you are seeking healthcare services from:

Amy Lovelace

Joel Ackerman

Have you received massage therapy before? _____

How did you hear about this massage therapy practice? _____

Why are you seeking massage therapy? Please describe the location of any tissue or joint discomfort: _____

Please list all other healthcare practitioners you are seeing:

1. _____ 2. _____ 3. _____

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What is your occupation? _____

Please describe what forms of exercise you participate in, and how often:



MEDICAL HISTORY

Please list any hospitalizations, surgeries, traumas or major illnesses:

1. _____ Date started: _____ Date Resolved: _____
2. _____ Date started: _____ Date Resolved: _____
3. _____ Date started: _____ Date Resolved: _____

Please indicate conditions you are experiencing or have experienced:

<p>Cardiovascular:</p> <ul style="list-style-type: none"><input type="checkbox"/> high/low blood pressure<input type="checkbox"/> congestive heart failure<input type="checkbox"/> heart attack<input type="checkbox"/> phlebitis/varicose veins<input type="checkbox"/> stroke/CVA<input type="checkbox"/> pacemaker or similar device<input type="checkbox"/> heart disease <p>Respiratory:</p> <ul style="list-style-type: none"><input type="checkbox"/> chronic cough<input type="checkbox"/> shortness of breath<input type="checkbox"/> bronchitis<input type="checkbox"/> asthma<input type="checkbox"/> emphysema <p>Head/Neck:</p> <ul style="list-style-type: none"><input type="checkbox"/> history of headaches<input type="checkbox"/> history of migraines<input type="checkbox"/> vision problems<input type="checkbox"/> vision loss<input type="checkbox"/> ear problems or hearing loss	<p>Infections:</p> <ul style="list-style-type: none"><input type="checkbox"/> hepatitis<input type="checkbox"/> skin conditions<input type="checkbox"/> TB<input type="checkbox"/> HIV<input type="checkbox"/> herpes <p>Women:</p> <ul style="list-style-type: none"><input type="checkbox"/> pregnant, due: _____<input type="checkbox"/> gynaecological conditions: _____ <p>Emotional Health: On a scale of 1 (low) to 10 (high), how would you rate the following:</p> <p>Stress level: _____</p> <p>Energy level: _____</p> <p>Happiness: _____</p>	<p>Other Conditions (please describe):</p> <ul style="list-style-type: none"><input type="checkbox"/> loss of sensation: _____<input type="checkbox"/> diabetes, onset: _____<input type="checkbox"/> allergies/hypersensitivity: _____<input type="checkbox"/> epilepsy<input type="checkbox"/> cancer _____<input type="checkbox"/> skin condition _____<input type="checkbox"/> arthritis _____<input type="checkbox"/> osteoporosis<input type="checkbox"/> bleeding disorder<input type="checkbox"/> digestive concerns<input type="checkbox"/> mental illness<input type="checkbox"/> Other: _____
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Do you have any internal pins, wires, artificial joints, or special equipment (please describe)? _____

Please list any medications, supplements, or herbs you are taking:

1. _____ 4. _____
2. _____ 5. _____
3. _____ 6. _____

Is there anything else you would like to include on this form? _____

Thank you.



INFORMED CONSENT FOR TREATMENT

"The practice of massage therapy is the assessment of the soft tissue and joints of the body and the treatment and prevention of physical dysfunction and pain of the soft tissues and joints by manipulation to develop, maintain, rehabilitate or augment physical function, or relieve pain." *Massage Therapy Act, 1991*

All information collected is to help formulate a clinical understanding of your condition and will be kept confidential, except where required by law, or to facilitate a diagnosis. A signed consent form is required before I contact any other health provider for your personal health information.

An up to date and accurate health history is essential to the delivery of appropriate techniques associated with massage therapy treatments. Please advise me if you are receiving care from another health care provider for any condition, and provide me with a complete list of all medications, including over the counter drugs and supplements, to assist me in determining whether modifications to your treatment are required. Please inform me of any allergy or hypersensitivity reaction you may have to any oils, lotions, laundry detergents, fabric softeners etc.

An assessment of your condition or physical discomforts may be necessary to determine the best course of action for treatment and your first treatment has been allotted extra time for assessment purposes. Throughout the course of treatments, additional time for reassessments may be required and may cut into your appointment time.

Benefits of massage therapy services can include but are not limited to increased mobility, increased flexibility, decreased stress or anxiety, and relief of muscle or joint pain.

Potential risks and/or side effects associated with massage therapy can include but are not limited to bruising, swelling, tissue congestion, nausea, dizziness, temporary muscle tenderness or soreness, and aggravation of existing symptoms.

After every massage treatment it is important to stay hydrated by drinking plenty of water to help flush out any toxins released from the tissues during the massage, unless fluid intake is restricted by a physician. It is also advised that you apply cold to any tender or sore areas to decrease tissue congestion and chances of bruising.

Results vary from person to person depending on the goals of the individual. Following home care suggestions will help you achieve your goals; however, it may be necessary to seek out other health care providers to assist in achieving your health goals.

STATEMENT OF ACKNOWLEDGEMENT

I have read the above statement and acknowledge that I am able to withdraw my consent and discontinue treatment at any time. I also understand that I have the right to ask any questions about any aspect of the assessment, treatment, and any of the information being collected, as it relates to me and my treatment plan.

SIGNATURE

DATE

WITNESS



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CONSENT FOR COLLECTION, USE, AND DISCLOSURE OF PERSONAL HEALTH INFORMATION

Your health privacy is a primary concern and the personal health information you disclose to your Registered Massage Therapist during your appointments will be handled in accordance with current privacy legislation. Personal health information includes identifiable information such as age, gender, family status, and health history.

Your Registered Massage Therapist, employees, and health practitioners of 541 Palace Road will collect, use, and disclose information about you for the following purposes:

- To assess your health concerns;
- To provide health care and advise you of treatment options;
- To communicate with other health providers;
- To establish and maintain contact with you;
- To invoice for goods and services, process credit card payments; and
- As required by law.

Employees and health practitioners of 541 Palace Road will have access to your record of personal health information and may come into contact with personal health information that is sent to or from the clinic. Staff members and practitioners will collect, use, and disclose your personal health information accordingly to protect your privacy and the confidentiality of your information.

I have reviewed the above information and authorize my Registered Massage Therapist, employees, and health practitioners of 541 Palace Road, to collect, use, and disclose my personal health information as outlined above.

NAME

DATE

SIGNATURE

WITNESS