MassageExperts.ca
Feel Better. More Often.

MASSAGE EXPERTS HEALTH HISTORY FORM

Please take a moment to fill out this confidential form
before your treatment begins, Thank you.

First name:		Last Name:
Birthdate:	Gender: F M	Phone Number:
Email:		
YES NO	May we send you emails regarding marketing promotions from Massage Experts Franchising Ltd. or it's independent clinics. You can withdraw this consent at anytime.	
Address:	City:	Prov:
Postal Code:	Emergency Contact Name:	
Occupation:	Emergency Contact Number:	Relation:
Have you received an RMT massage before? YES NO	Do you have a Doctor Referral? YES NO	
Primary Physician Name:		
Address:	Phone Number:	
Do you see any other health care professionals? YES NO … Chiro Physio Naturopath Osteopath		

Please Indicate the conditions you are currently or regularly experience:

Cardiovascular:
- ☐ High Blood Pressure
- ☐ Low Blood Pressure
- ☐ Chronic Congestive Heart Failure
- ☐ Heart Attack
- ☐ Phlebitis/ Varicose Veins
- ☐ Stroke / CVA
- ☐ Pacemaker or Similar Device
- ☐ Heart Disease
- ☐ Poor Circulation
- ☐ High Cholesterol
- ☐ Chest Pains
- ☐ Other:_____

Head/ Neck Issues:
- ☐ Headaches
- ☐ Migraines
- ☐ Vision Problems/ Loss
- ☐ Hearing Problems/ Loss
- ☐ Vertigo
- ☐ Dizziness
- ☐ Concussion
- ☐ Thyroid issues
- ☐ Epilepsy
- ☐ Other:_____

Women:
- ☐ Pregnant, Due date:_____
- ☐ Gynaecological Conditions
- ☐ Breast Cancer
- ☐ Fibroids
- ☐ Other:_____

Respiratory:
- ☐ Chronic Cough
- ☐ Shortness of Breath
- ☐ Bronchitis
- ☐ Asthma
- ☐ Emphysema
- ☐ Smoker
- ☐ Other:_____

Infections:
- ☐ Fever/ Flu/ Cold
- ☐ Hepatitis Type:_____
- ☐ TB
- ☐ HIV/ AIDS
- ☐ Herpes:_____
- ☐ Other:_____

Other Conditions:
- ☐ Diabetes, Type:_____
  & Injections YES NO, area_____
- ☐ Cancer, Type/Where:_____
- ☐ Skin Conditions :_____
- ☐ Other:_____

Mental:
- ☐ Anxiety disorders
- ☐ Depression
- ☐ ADHD/ ADD
- ☐ Bipolar
- ☐ Schizophrenic
- ☐ Lack of Energy/ Easily Tired
- ☐ Poor Sleeping Habits
- ☐ Other:_____

Nervous System:
- ☐ Numbness/Tingling _____
- ☐ Loss of Sensation
- ☐ Bells Palsy
- ☐ Cerebral Palsy
- ☐ MS
- ☐ Fibromyalgia
- ☐ Carpal Tunnel
- ☐ Sciatica
- ☐ Other:_____

Skeletal:
- ☐ Arthritis, Type:_____ & Where_____
- ☐ Osteoporosis
- ☐ Pins, plates, Screws, _____
- ☐ Bursitis
- ☐ TMJ/ Jaw Pain
- ☐ Artificial Joints,_____
- ☐ Other:_____

Lymphatic:
- ☐ Edema/ Swelling
- ☐ Lymph Node Removal
- ☐ Lymphedema
- ☐ Other:_____

Gastrointestinal/Urinary:
- ☐ Acid Reflux/ GERD
- ☐ Kidney Stones
- ☐ UTI
- ☐ Other:_____

Is there a Family History of any of the above conditions? YES NO …What?

Allergies: YES NO , If yes to what: & Reaction:

Medications: YES NO , If yes Name & Condition it treats (include vitamins and prescribed meds):

Do you regularly see an RMT: YES NO , how often? First Time having an RMT massage? YES NO

Injuries:	Surgeries:

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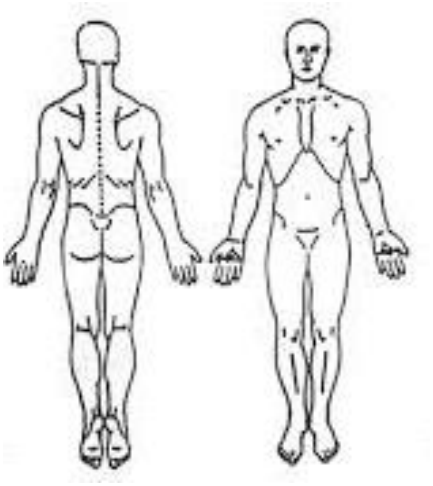
Please (Circle) if you are experiencing any joint/ muscle pain or discomfort anywhere



Notes:

☐ Scalp/ Head/ Jaw o Left o Right ☐ Neck o Left o Right ☐ Shoulders o Left o Right ☐ Arms o Left o Right ☐ Elbows o Left o Right ☐ Hands o Left o Right	☐ Back o Upper o Middle o Lower o Left o Right ☐ Hips o Left o Right ☐ Legs o Left o Right ☐ Knees o Left o Right ☐ Feet o Left o Right

Please share with us how you discovered us: Facebook Newspaper Walk-in Medical Referral Search Engine Other

Referred by a Friend/ Family member? YES NO Their Name:

Privacy Policy

Your personal information is protected and completely confidential. In accordance with the College of Massage Therapists of Ontario (CMTO), Registered Massage Therapists require the Health History information to provide the client with safe and effective treatment. Health history forms will be updated annually to ensure your records are accurate and complete. You will be asked to provide written authorization for the release of any information in your file. Treatment records will be kept for a period of 10 years after your last treatment date or, if under 18 at the time of treatment, records will be kept for 10 years after your 18th birthday. If you need to access, update, or correct your records, please contact our via email or call us.

Consent Policy

In order for you to provide informed consent to treatment, at the start of each session we will discuss any concerns as well as your treatment plan including the benefits, risks, and alternate therapies available for treatment. Massage Therapists provide assessments but not a medical diagnosis. You will be referred to your family physician or an appropriate health care professional when necessary. When explaining a proposed treatment, your RMT will describe the nature of the treatment, the expected benefits, any risks or side effects of the proposed therapy, alternative options, and any consequences of not having the treatment.
A client may withdraw or modify consent to treatment at any time, and the request will be respected immediately**. With signing below you are giving consent for your RMT to give you treatments. If at any time you wish to withdraw or modify your consent it will be recorded into your health records file.**

Receipts

As a Registered Massage Therapist with the College of Massage Therapists of Ontario (CMTO), **we will provide an official receipt** for each Massage Therapy treatment you have at our clinic. Many extended health plans cover Massage Therapy when provided by a RMT**.**
A referral note from your doctor may be required for coverage. Contact your extended health plan representative to receive the specific coverage your plan offers. Direct Billing Options are available; please discuss billing options with the front desk staff.

Cancellation, Late Arrival & No Show Policy

If you are unable to attend a scheduled appointment, please call to cancel the appointment with a minimum of 24 hours prior to the start of your treatment time. **Failure to be present or cancel with proper 24Hour notice, for a scheduled appointment will result in being charged the full rate for the missed appointment.** As late arrival reduces your treatment time, please arrive on time or 5 minutes early. Full session fees will apply when a late arrival does occur. **With signing below, you are agreeing to our 24HR cancelation, no show and late arrival policy.**

Client Name: (Print)	
Client Signature:	**Date:**
RMT Signature:	

**Please note that if you are doing Direct Billing and your insurance company requires a Doctors Referral, we need a copy **