DEEP ROOTED MASSAGE

# Health History Form

## General Information:

Name: _____ Date of birth _____

Address/City/Postal Code: _____

Phone: _____ Emergency Contact: _____

Other Phone:_____ Emergency Contact

Email:_____ Number:_____

Occupation:_____

Have you had a massage before? Yes No

Reason for massage: _____

Current medications? _____

Any medical conditions: _____

Do you have any allergies? _____

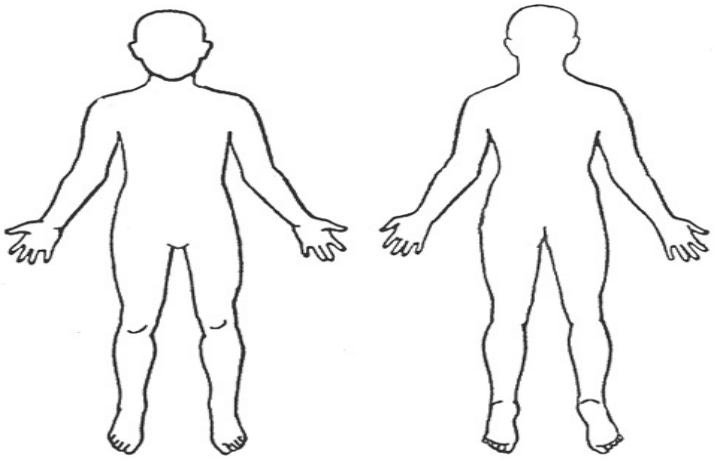
Previous Injuries or Surgeries? _____

Do you have any internal pins, wires, artificial joints or special equipment? Yes No

What/Where? _____

Who can we thank for referring you? _____

Indicate pain/stiffness with an "X " and shade areas of tingling/numbness



Is there anything else you would like us to know?

Date of initial:_____
Update 1:_____
Update 2:_____
Update 3:_____
Update 4:_____

Health History: please mark C for current, P for past and F for family history.

**Skin**
Rashes___
Itching___
Easily bruise___
Dryness___
Boils___
Other:_____

**General Symptoms**
Fainting___
Dizziness___
Loss of sleep___
Fatigue___
Nervousness___
Sudden weight loss/gain___
Numbness___
Tingling___
Loss of sensation ___
Paralysis___

**Cardiovascular**
High blood pressure___
Low blood pressure___
Coronary heart disease___
Heart attack___
Stroke___
Pacemaker___
Heart Murmur___
Palpations___
Varicose Veins___
Poor Circulation___

**Infectious**
Hepatitis___
Tuberculosis___
HIV___
Herpes___
Cold___
Flu___
Warts___

**Respiratory**
Chronic cough___
Shortness of breath___
Bronchitis___
Asthma___
Emphysema___

**Head/Neck**
Headaches___
Migraines___
Vision problems/loss___
Ear problems/ hearing loss___

**Other**
Diabetes___
Epilepsy___
Cancer___
Arthritis___
Depression___
Anxiety ___

**Please fill out if Pregnant:**

1.Do you see an Obstetrician, Family M.D. or Midwife? If so who?
_____

2.Frequency of visits to M.D/OB/Midwife?
_____

3. # of weeks pregnant (gestational age) _____
Due Date _____

4. Are you planning a home birth or Hospital Birth:
_____

5. Do you have any other children?
_____

6. Any issues related to pregnancy?
_____

7. Any muscle concerns related to pregnancy?
_____

8. What is your current approximate blood pressure?
_____

9. Are you seeing any other health care providers/complementary Practioners during your pregnancy? _____

# Deep Rooted Massage: Client Agreement

This form has been outlined so that you may fully understand the office policies pertaining to this clinic. It is advisable that you fully read and understand this form before signing. Please feel free to ask us any questions.

- All information on the health history form is essential to giving you the most effective and safe treatment possible. Please understand that everything discussed/recorded is strictly confidential and no information may be released or discussed with anyone without your consent. Deep Rooted Massage is not responsible for any injury or harm that may occur though the omission (either knowingly or mistakenly) of certain health related details in the health history form
  • RMT's working within Deep Rooted Massage share patient/client files with your consent therefore if you chose to be treated by an alternate therapist, that therapist will have access to your notes and assessments.
  • As a new Patient/Client it is necessary to have full assessment performed before your initial treatment. This is required so that a safe, relevant and effective treatment plan can be set up for you. New health history forms must be completed or revised after a client has been absent from treatment for a long period of time, when seeing a new therapist for the first time and /or if your health status changes dramatically. The assessment is part of the initial treatment and may take up to the first half hour of the session. A new health history form must be filled out and a re-assessment must take place every year to ensure all information is up to date
  • In signing this form you acknowledge the fact that this clinic is therapeutically based and follows the strict guidelines of the Regulated Health Practitioners Act and The College of Massage Therapists of Ontario. If at any time you are uncomfortable and wish to alter the treatment plan or application of treatment, please feel free to discuss this with your therapist so that your needs are fully addressed.
  • Payments can be made in either debit, cheques, credit or cash and a receipt will be issued to you following treatment.
  • Missed appointments without 24 hours notice will be issued a 50% charge of the time scheduled except in the event of a family emergency or illness.
  • Please arrive 15 minutes prior to your scheduled appointment time. In the case of late arrivals it is fully understood that only the time remaining for your scheduled treatment will be allotted unless additional time is available. Due to the lack of secretarial staffing reminder calls are NOT office policy however an appointment care can be issued upon booking a subsequent treatment.
  • It is not the policy of this clinic to work through WSIB of MVA claims; However if you require a therapist that does treat therapeutically under WSIB or MVA claims then a new therapist in the area will be suggested to you.
  • Clients under the age of 18 must have a parent or legal guardian accompanying them for the initial assessment/treatment and must co-sign this document. If a client is under the age of 16 a parent or legal guardian must be present for all assessments and treatments that my follow.

By signing this agreement you are consenting to have read and understood the above information completely and entirely.

Name (Print): _____

Signature: _____

Date: _____