

Kanata Massage at Awakening Potentials Inc. Registered Massage Therapy Health History Form

The information request below will assist us in treating you safely. Feel free to ask any questions about the information being requested. Please note that all information provided below will be kept confidentially unless allowed or required by law. Your written permission will be required to release any information.

Name: _____ Phone # _____

Address: _____

Occupation: _____ Date of Birth: _____

Have you received massage therapy before? Yes ___ No ___

Did a health care practitioner refer you for massage therapy? Yes ___ No ___

If yes, please provide their name and address: _____

Please indicate conditions you are experiencing or have experienced:

<p>Cardiovascular</p> <p>___ high blood pressure ___ low blood pressure ___ chronic congestive heart failure ___ heart attack ___ phlebitis/varicose veins ___ stroke/CVA ___ pacemaker or similar device ___ heart disease</p> <p>Is there a family history of any of the above? ___ Yes ___ No</p>	<p>Infections</p> <p>___ hepatitis ___ skin conditions ___ TB ___ HIV ___ herpes</p> <p>Other Conditions</p> <p>___ loss of sensation, where? _____ ___ diabetes, onset _____ ___ Allergies/hypersensitivity to what? _____ Type of reaction _____ ___ epilepsy ___ cancer, where? _____ ___ skin conditions, what? _____ ___ arthritis</p> <p>Is there a family history of arthritis? ___ Yes ___ No</p>	<p>Head/Neck</p> <p>___ history of headaches ___ history of migraines ___ vision problems ___ vision loss ___ ear problems ___ hearing loss</p> <p>Women</p> <p>___ pregnant, due: _____ ___ gynecological conditions, what? _____</p> <p>How's your general health? _____</p> <p>Primary Care Physician: _____</p> <p>Address _____</p>
<p>Current Medications _____</p> <p>Conditions it treats: _____</p> <p>Are you currently receiving treatment from another health care professional ___ Yes ___ NO If yes, for what? _____</p> <p>Surgery – date: _____ Nature: _____</p> <p>Injury – date: _____ Nature: _____</p>	<p>Do you have any other medical conditions? (e.g. digestive conditions, hemophilia, osteoporosis, mental illness) ___ Yes ___ No What? _____</p> <p>Do you have any internal pins, wires, artificial joints or special equipment? ___ Yes ___ No What? _____ Where? _____</p> <p>What is the reason you are seeking massage therapy? Please include the location of any tissue or joint discomfort. _____</p>	

Notes:

<p>Date of Initial Health History: _____</p> <p>Update 1 _____</p> <p>Update 2 _____</p> <p>Update 3 _____</p> <p>Update 4 _____</p>
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Kanata Massage Consent Form

Massage therapy is the manipulation of soft tissues of the body to gain a therapeutic response. Soft tissues include: muscles, skin and connective tissue. (tendons, ligaments and membranes)

The confidential health history provided by you is required to assist in forming an assessment and treatment plan, which will be explained to you before treatment. This will help you to understand the processes behind your pain and how we can work together to alleviate it. You will be asked to provide written authorization for the release of any information. Please inform your therapist should anything change regarding your health status. You may stop treatment at any time, and questions before, during or after therapy are highly encouraged.

I, _____ understand that by its very nature massage therapy may cause minor discomfort and may irritate the skin or leave a mark like a bruise. There are cases where symptoms may get worse before they get better. I understand that if my condition worsens, I should get in touch with the registered massage therapist and /or seek other appropriate medical care.

I realize no claims, promises, or guarantees are being made, I accept full responsibility for the risk and effectiveness of all treatment.

I have read this agreement and agree to it:

Client's Printed Name

Client's Signature

Witness' Printed Name

Witness' Signature

Date: _____