Health History Form

Name: _____ Phone #: _____

Address: _____ City: _____

Occupation: _____ Date of birth: _____

The information requested below will assist us in treating you safely. Fill in the form completely prior to meeting with your RMT and don't hesitate to ask any questions about the information being requested.

Have you ever received massage therapy before? ☐ Yes ☐ No

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

Please indicate conditions you are experiencing or have experienced:

Cardiovascular

- ☐ high blood pressure
- ☐ low blood pressure
- ☐ chronic congestive heart failure
- ☐ heart attack
- ☐ phlebitis / varicose veins
- ☐ stroke / CVA
- ☐ pacemaker or similar device
- ☐ heart disease

is there a family history of any of the above?

☐ Yes ☐ No

Infections

- ☐ hepatitis
- ☐ skin conditions
- ☐ TB
- ☐ HIV
- ☐ herpes
- ☐ warts or fungus
- ☐ other:

Head / neck

- ☐ history of headaches
- ☐ history of migraines
- ☐ vision problems
- ☐ vision loss
- ☐ ear problems
- ☐ hearing loss
- ☐ other:

Respiratory

- ☐ chronic cough
- ☐ shortness of breath
- ☐ bronchitis
- ☐ asthma
- ☐ emphysema
- ☐ C.O.P.D.

is there a family history of any of the above?

☐ Yes ☐ No

Other:

- ☐ pregnant, due? _____
- ☐ gynecological conditions, what? _____

Other conditions

- ☐ loss of sensation, where? _____
- ☐ diabetes, onset: _____
- ☐ allergies / hypersensitivity to what? _____
- ☐ epilepsy
- ☐ cancer, where? _____
- ☐ are you currently in remission? _____
- ☐ skin conditions, what? _____
- ☐ arthritis

is there a family history of any of the above? ☐ Yes ☐ No

Overall

How is your general health? _____

Primary care physician: _____ Address: _____

Current Medications: _____ condition it treats: _____

Are you currently receiving treatment from another health care professional? ☐ Yes ☐ No for what? _____

Surgery - date: _____ nature: _____

Injury - date: _____ nature: _____

Do you have any other medical conditions? (e.g digestive conditions, haemophilia, osteoporosis, mental illness) ☐ Yes ☐ No

what? _____

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

where? _____

What is the reason you are seeking massage therapy? Please include the location of any tissue or joint discomfort: _____

Note: a review and discussion of your health history form will be part of your treatment time.

Signature: _____ Date: _____

Privacy Notice: Scandinave Spa Blue Mountain respects your privacy. All the information provided on this form will be kept confidential, unless required by law and with your consent. Your personal information will not be shared with third parties for the purpose of marketing or selling their products or services.

FOR OFFICE USE ONLY

Dates of initial and updated Health History

History: _____

Update 1: _____

Notes:

Client Name: _____

TO BE FILLED OUT ONLY AFTER DISCUSSION WITH, AND IN THE PRESENCE OF YOUR RMT

Written Consent if there is an Assessment and/or Treatment planned for Sensitive Areas

I, (client name) _____ , have requested assessment and/or treatment by this Registered
(print)
Massage Therapist (RMT) _____ (name) for treatment of the clinically relevant areas indicated below (please initial):

_____ Buttocks (gluteal muscles) _____ Chest Wall Muscles

_____ Upper Inner Thigh(s) _____ Breast (s)

The RMT has explained to me the nature of the assessment/treatment, including the clinical reason(s) for assessment/treatment of the above area(s); draping methods & massage techniques to be used; expected benefits, potential risks and potential side effects of the assessment. It has also been explained that my consent is voluntary and I can alter or withdraw my consent at any time. As a result, I fully understand the proposed assessment and/or treatment.

I voluntarily give my informed consent for the assessment and/or treatment as discussed and outlined above.

Client Signature: _____ Date: _____

Client Signature Update 1: _____ Date: _____

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Date: _____ Time: _____ am / pm Duration: _____ min/hr Massage Started at: _____ Fee: $

Treatment plan/goal: ☐ General Relaxation/De-stress Other: _____ RMT Name:

Areas to be treated: ☐ Head ☐ Face ☐ Neck ☐ Clavicle ☐ Scalp ☐ Arm L / R ☐ Hand L / R ☐ Leg L / R ☐ Foot L / R
☐ Back ☐ Hip ☐ Shoulder ☐ Other:

Techniques to be used: ☐ General Swedish ☐ Hydrotherapy ☐ Deep Fascial ☐ Trigger Points ☐ Frictions ☐ Stretch ☐ Joint Mobilization
☐ Hot Stone ☐ Other:

☐ Verbal Informed Consent received for above Treatment Plan ☐ Verbal Informed Consent received for assessment

Post Treatment: ☐ Treatment Plan carried out as planned ☐ Treatment altered at clients request during treatment

Amount of pressure used: ☐ Very Light ☐ Light ☐ Medium ☐ Heavy ☐ Very Heavy

Other Notes: _____

☐ Room cleaned and sanitized.

☐ Guest & RMT wore a mask.

☐ COVID health screening.