HEALTH HISTORY FORM

Name: _____ **Date:** _____

Address: _____ **City:** _____

Occupation: _____ **Date of Birth:** _____

The information requested below will assist your Massage Therapist in treating you safely. Fill in the form completely prior to meeting with your RMT. Please do not 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
- ☐ herpes
- ☐ warts or fungus
- ☐ other:

OTHER:

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

HEAD / NECK

- ☐ history of headaches
- ☐ history of migraines
- ☐ vision problems
- ☐ vision loss
- ☐ 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 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 family history of any of the above? ☐ Yes ☐ No

OVERALL How is your general health? _____

Primary Care Physician: _____ Address: _____

Current Medications: _____ conditions 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? (ie. digestive conditions, haemophilia, osteoporosis, mental illness? ☐ Yes ☐ No

for 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: _____

PLEASE NOTE: A review and discussion of your health history 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

Client Name: _____ **Date:** _____ **Time:** _____ **AM / PM**

Type of Massage booked: ☐ Swedish ☐ Therapeutic ☐ Prenatal ☐ DUO Duration: _____ min / hour Fee: $ _____

Pick up Time: _____ Start Time: _____ Finish Time: _____ RMT Name: _____

TREATMENT PLAN

Client goals: Primary _____ Secondary: _____

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

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

☐ **Verbal Informed Consent Received for above Treatment Plan.** ☐ **Verbal Informed Consent Received for Assessment**

CLIENT SIGNATURE FOR TREATMENT PLAN AND INFORMED CONSENT: _____

Written Consent if there is an Assessment and/or Treatment planned for Sensitive Areas.
To be filled out only **AFTER** discussion with, and in the presence of the treating RMT.

I, (client name) _____, have requested assessment and/or treatment by this Registered 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: _____

POST TREATMENT SOAP NOTES

☐ Treatment Plan carried out as planned ☐ Treatment Planned altered at clients request during treatment _____

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

Other Notes:

_____

_____

_____

_____

_____

☐ Room cleaned and sanitized ☐ COVID/Health screening done ☐ Guest wore a mask ☐ RMT wore a mask