Christianne James RMT

Initial Health History Form

An accurate health history is important to ensure that it is safe for you to receive massage therapy. All information gathered for this treatment is confidential except as required or allowed by law. Written authorization will be required for release of any information. You must notify your RMT if there are any changes in your health history.
24 hour cancellation notice is required otherwise a missed appointment fee will be charged.

Legal Name: _____ Tel. Res.: _____ Tel. Bus.: _____

Address: _____ City: _____ Prov.: _____ Postal Code: _____

Date of Birth: ___/___/___ (mm dd yy) Occupation: _____ Male: ❑ Female: ❑ 1st Massage Therapy Treatment? ❑ Yes ❑ No

Primary Health Care Physician: _____ Address: _____ Tel.: _____

Primary Complaint: _____ Source of Referral: _____

General Health Status: _____

Are you seeing other Health Care Professionals? If yes Please specifiy _____

Please indicate conditions you are or have experienced with a check mark: ☑

Soft Tissue/Joints
(specify its nature i.e. pain, stiffness, numbness etc.)

- ❑ neck _____
- ❑ shoulder _____
- ❑ upper back
- ❑ mid back
- ❑ low back
- ❑ arms _____
- ❑ legs _____
- ❑ knees _____
- ❑ hip _____
- ❑ other: _____

Headaches

- ❑ tension ❑ migraines
- ❑ tooth/jaw/ear pain
- ❑ head trauma - date: _____
- ❑ other: _____

GI tract conditions

- ❑ IBS ❑ Crohn's
- ❑ constipation
- ❑ other: _____

Accident/Injury

- ❑ car accident work related? ❑ Yes ❑ No
- ❑ date: _____
- ❑ symptoms: _____
- ❑ Physical limitations: _____

Have you had any Surgeries?

- ❑ type: _____
- ❑ date: _____
- ❑ symptoms: _____

Respiratory

- ❑ chronic cough
- ❑ shortness of breath
- ❑ bronchitis
- ❑ asthma - triggers: _____
- ❑ emphysema
- ❑ pneumonia
- ❑ sinus problems

Cardiovascular

- ❑ high blood pressure
- ❑ low blood pressure
- ❑ heart attack - date: _____
- ❑ phlebitis
- ❑ stroke/CVA - date: _____
- ❑ pacemaker
- ❑ heart disease
- ❑ angina
- ❑ chronic congestive heart failure

Infectious Disease

- ❑ hepatitis
- ❑ infectious skin conditions
- ❑ tuberculosis
- ❑ HIV
- ❑ other: _____

Women

- ❑ pregnant/due date: _____
- ❑ previous labour complications: _____

Current medication & conditions

Skin

- ❑ skin condition
  specify: _____
- ❑ bruise easily
- ❑ herpes
- ❑ varicose veins
- ❑ athletes foot
- ❑ loss of sensation

Other Conditions

- ❑ neurological condition: _____
- ❑ epilepsy - triggers: _____
- ❑ diabetes/onset: _____
- ❑ allergies: _____
  anaphylaxis? ❑ Yes ❑ No
  skin irritation? ❑ Yes ❑ No
- ❑ cancer
- ❑ arthritis - where? _____
  type? ❑ RA ❑ OA other: _____
  Family History? ❑ Yes ❑ No
- ❑ vision loss
- ❑ hearing loss
- ❑ insomnia
- ❑ hemophilia
- ❑ kidney/bladder problems
- ❑ other: _____

Do you have any Pins/Wires/Prosthetics?

- ❑ Yes specify: _____
- ❑ No _____

Do you have a family history of ANYof the above conditions?

I have read the above information and have truthfully stated all my previous and current medical conditions. I understand that all massage treatments will be discussed an planned with the massage therapist and will require my informed consent.

Signature: _____ Date: _____

Christianne James RMT

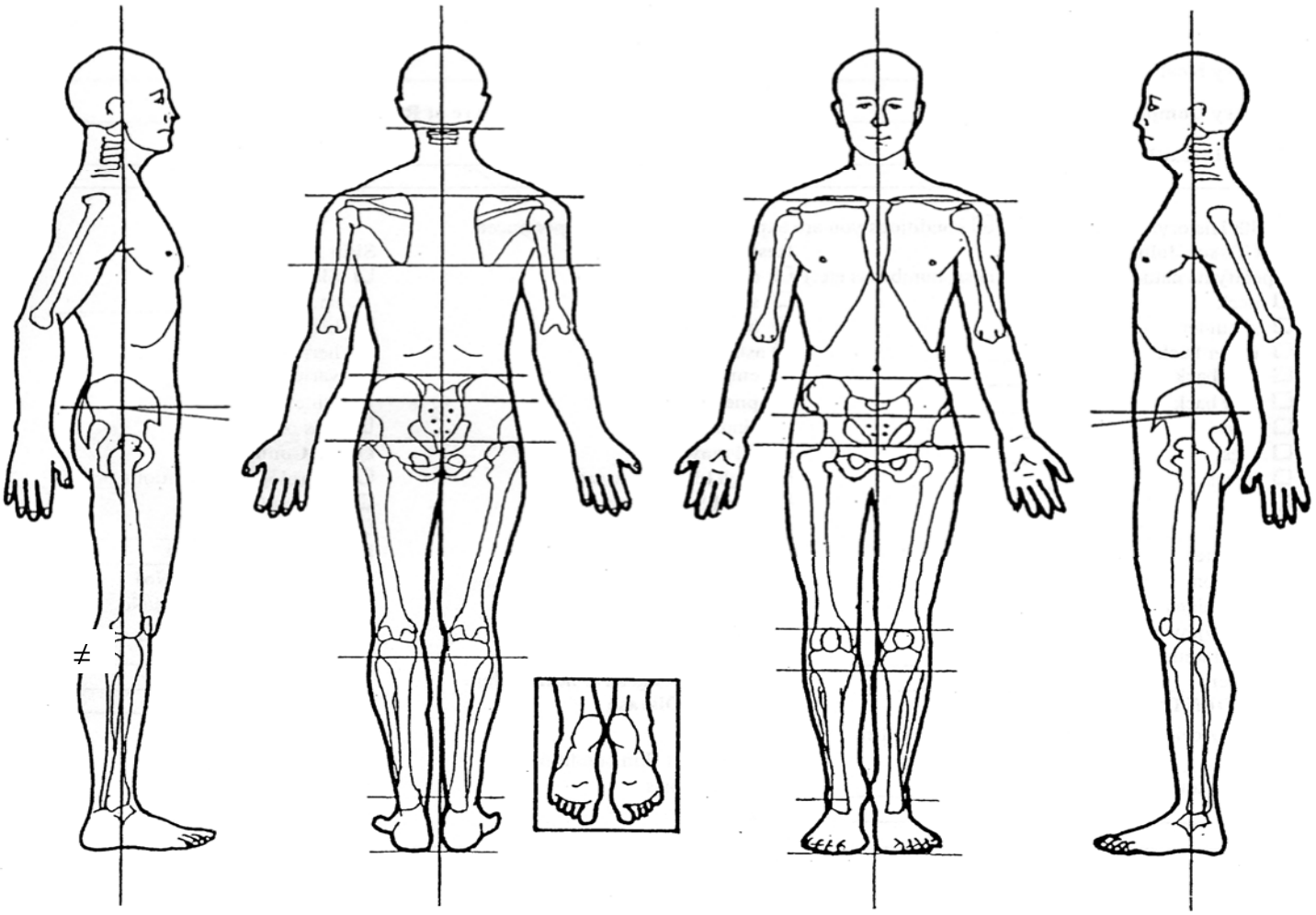
Client Name: _____

Date: _____

Assessment of Pain and Treatment Area Diagram

jsd

Please indicate where you feel pain, tension or numbness by circling the area. Or use the legend below if you know the specific cause and problems within the area of concern.



tension: //// trigger point: X tender point: 0 pain: ⬭ adhesion: ≠ parasthesia: ∿∿ scars, bruises, wounds: ▲

UPDATED

Date: _____ Client Signature: _____

Date: _____ Client Signature: _____

Date: _____ Client Signature: _____

Date: _____ Client Signature: _____

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On going Treatment Form

Client: _____

Date: _____ Appt.Time: _____ Duration: _____ Price: _____ Informed Consent: ❑ Yes ❑ No

Special Consent Areas: _____ Special Consent ☐ Yes ☐ No

Client Concerns: _____

Objective: _____

Assessment: _____

Tx Areas: _____

Techniques Used: _____

Post Tx Assessment: _____

Client Feedback _____

Tx Plan/Self-care: _____

Date: _____ Appt.Time: _____ Duration: _____ Price: _____ Informed Consent: ❑ Yes ❑ No

Special Consent Areas: _____ Special Consent ☐ Yes ☐ No

Client Concerns: _____

Objective: _____

Assessment: _____

Tx Areas: _____

Techniques Used: _____

Post Tx Assessment: _____

Client Feedback _____

Tx Plan/Self-care: _____