Christianne James, DO (MP), 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: ______________

Pinewood Natural Health Centre

220 Duncan Mill Road, Unit 110, Toronto ON M3B 3J5
1295 Wharf Street, Unit 11, Pickering ON L1W 1A2

Consent to Assessment, Treatment & Disclosure of Information

The Ontario Government prefers patients to give consent to treatment in writing. By signing this consent form you acknowledge that you consent to an assessment and treatment and have had your questions about treatment answered to your satisfaction.

Massage Therapy/Osteopathy in general includes a variety of manual techniques where the health practitioner places his or her hands on your body. Many techniques will involve contact between your body and the health practitioner's body. Christianne James, DO(MP), RMT, CMAP, BSc, BHA uses an integrative approach to treatment, combining cranio-sacral, visceral, osteoarticular, and soft tissue/myofascial techniques as a means of treating presenting areas of dysfunction. Body and hand contact may include areas of your anterior chest wall, abdomen, tailbone, pelvic floor, and pubic bones. Depending on signs and symptoms, intra-oral treatment may also be required. A disposable vinyl glove will be worn.

For assessment and/or treatment purposes, you may be asked to wear loose fitting clothing such as a t-shirt and shorts.

If you do not feel comfortable with a given technique, please indicate that. An explanation will be provided to explain what you may be experiencing, and what may be occurring mechanically/physiologically. The technique will be modified or discontinued to assure your comfort.

Pinewood Natural Health Centre is a multidisciplinary office and in order to provide concurrent care, it may be necessary to release or obtain pertinent medical information, regarding your condition(s) for which you are being treated, from/to other Pinewood health practitioner(s) you have sought assessment or treatment from.

By signing this form you give consent for assessment, treatment and disclosure of information.

____ ________________________

Patient or Guardian /Parent Signature Date (dd/mm/yyyy)

____

Witness

Cancellation Policy

Please provide us with a minimum of 24 hours of notice if you find it necessary to cancel your appointment. This will enable us to get in touch with other patients that require Christianne James' services and make arrangements for them to fill the time slot you have vacated.

We know that last minute changes in your schedule are sometimes impossible for you to avoid. However, Christianne James will charge a cancellation fee equal to 100% of the charges applicable to the original time reserved specifically for you, unless you are ill, or there is an extenuating circumstance. This fee will also apply when you arrive late for your appointment or request to leave early.

Thank you for helping us to maintain a high level of service for all patients of Christianne James.

I understand the above and agree to abide by the policy.

____ ________________________

Patient or Guardian /Parent Signature Date (dd/mm/yyyy)

____

Witness