



1200 Walkley Rd, Ottawa, ON, K1V 6P8

Client Health History Form

For your health:

An accurate health history is important to ensure that you receive a safe massage treatment. If your health status changes in the future, please let me know. All information gathered for this treatment is confidential except as required by law or except facilitate assessment and treatment. You will be asked to provide written authorization for release of any information.

Name: _____ Date: _____
Address: _____ Tel: Res: _____
_____ Bus: _____

Date of Birth (D/M/Y) _____ Occupation: _____
Email Address: _____

What brings you in for massage? _____
Cause (if known): _____ Are you being treated for this? _____
How did you hear of our service? (Dr. /sign/ massage therapy client....) _____

Your Physician's name and number: _____
May he/she be contacted about your treatment? _____
Emergency contact: _____ Their number: _____

My RMT has explained in detail the Massage Treatment that I am to receive including any possible side effects. By signing this form I am consenting to Treatment. I understand that I may withdraw my consent to be treated at anytime and as such time the Treatment will end immediately. I will keep my RMT informed of any positive or negative effects the Treatments have on me so that he / she can modify the Treatments to better suite me.

Health History Information

Do you exercise regularly? Y/N _____ Frequency: _____ Duration: _____

Please indicate conditions that you are currently experiencing, or have experienced in the past.

Head/Neck

___ Type
___ Headaches
___ Vision problems
___ Contact lenses
___ Earaches

Respiratory

___ Chronic cough
___ Shortness of breath
___ Smoking
___ Asthmas
___ Bronchitis
___ Emphysema

Cardiovascular

___ Difficulty breathing
___ High blood pressure
___ Poor circulation
___ Heart disease
___ Phlebitis
___ Stroke, date _____
___ Varicose veins
___ Arteriosclerosis
___ Heart Attack
 Date: _____
___ Pacemaker or Similar Device
___ Chronic Congestive Heart Failure

Skin

___ Bruise easily
___ Skin condition
___ Type

Arthritis

___ Cancer
___ Rheumatoid Arthritis
Where _____
___ Osteoarthritis
Where _____
Dr. Diagnosed? Y/N _____
___ Other

Other conditions

___ Difficult digestion
___ Constipation
___ Liver
___ Gall bladder
___ Kidney
___ Epilepsy
___ Diabetes, onset _____
___ Sinus
___ Allergies
___ Insomnia

Muscles / Joints

___ Neck Stiffness / Pain
___ Low Back Stiffness / Pain
___ Mid Back Stiffness / Pain
___ Upper Back Stiffness / Pain
___ Degenerative discs
___ Arm pain / tingling / Injury
___ Hip or thigh Pain
___ Knee Pain
___ Leg / Foot Pain
___ TMJ / Jaw / Tooth Pain
___ Repetitive strain / work injury
___ Tendinitis
___ Bursitis
___ Fracture
___ Fibromyalgia

Female

___ Menstrual Problems
If So, Painful? Y / N _____
___ Pregnant Due _____
___ Caesarian Section or Other
___ Gynecological Surgery
___ Children: Number _____
___ Menopausal Problems

Please list any Medications / Homeopathic / Naturopathic / Supplements and for what condition(s)

Surgery

Type _____
Date _____
Current Symptoms

Injury

Type _____
Date _____
Current Symptoms

Other Healthcare

___ Chiropractic
___ Physiotherapy

Other medical conditions / concerns: _____

Client Signature: _____ Date: _____