pine+ Wellness Centre
MARKHAM-STOUFFVILLE

6-114 Anderson Ave, 2nd Floor
Markham, ON L6E 1A5
905-554-7681

HEALTH HISTORY FORM

The information request below will assist us in treating you safely. Feel free to ask any questions about the information being requested. Please note that all information provided below will be kept confidentially unless allowed or required by law. Your written permission will be required to release any information.

Last Name:_____ First Name:_____ Date of Birth(dd/mm/yy):_____

Address:_____ City/Province :_____ Postal Code:_____ Male/ Female

Home Phone:_____ Work Phone:_____ Cell Phone:_____

Email:_____ Occupation:_____

Family Doctor:_____ Phone:_____ Address:_____

Have you received massage therapy before? Yes No Did a healthcare practitioner refer you for massage? Yes No

If yes, please provide their name and address _____

Please indicate conditions you are experiencing or have experienced in the past:

Cardiovascular

High blood pressure
Low blood pressure
Chronic congestive heart failure
Heart attack
Phlebitis/ varicose veins
Stroke/CVA
Pacemaker or similar device
Heart disease

Respiratory

Chronic cough
Shortness of breath
Bronchitis
Asthma
Emphysema

Is there a family history of any of the conditions on this list? Yes No

If yes, which of the above: _____

Infections

Hepatitis
Tuberculosis
HIV
Herpes

Other Conditions

Loss of sensation, where?
_____

Diabetes (type: _____)
-Onset:_____
Allergies/hypersensitivity to what:
_____

-Type of reaction: _____
Epilepsy
Cancer, where?
Skin condition, what?_____
Arthritis, type? _____

_____

Head and Neck

History of headaches
History of migraines
Vision problems
Vision loss
Ear problems
Hearing loss

Women

Pregnant, due: _____
Other: _____
_____

General Health

Overall, how is your general health?
Excellent/ Good/ Fair/Poor

Current Medications:

_____
_____
_____
_____

Condition it treats:

_____
_____
_____
_____

Are you currently receiving treatment from another health care professional?

None Chiropractor Psychologist
Physiotherapist Sports Therapist
Other: _____

Other Conditions Not Listed:

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

_____

Have you had previous injuries or surgery? _____

_____

Do you have any internal pins, wires, artificial joints or special equipment? _____

Reason For Today's Visit:

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

_____

I hereby declare that the above information is true. Signature:_____ Date: _____

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MASSAGE THERAPY INFORMED CONSENT

I,_____ (client) understand that massage therapy provided by_____(therapist) is intended to enhance relaxation, reduce pain caused by muscle tension, increase range of motion and improve circulation.

The general benefits of massage, possible massage contraindication and the treatment procedure have been explained to me. I understand that massage therapy is not a substitute for medical treatment or medications, and that it is recommended that I concurrently work with my Family Doctor for any condition I may have. I am aware that the massage therapist does not diagnose illness or disease, does not prescribe medications, and the spinal manipulations are not part of massage therapy.

I have informed the therapist of all my known physical conditions, medical conditions, and medication, and I will keep the therapist updated on any changes. I understand that there shall be no liability on the practitioner's part due to my forgetting to relay any pertinent information.

If I experience any pain or discomfort during the session, I immediately communicate that to the therapist so the treatment can be adjusted.

_____ _____

Client Signature Date

_____ _____

Witness Signature Date