Health History Form

Jennifer Pullen, RMT

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

PERSONAL INFORMATION

Name: _____ Today's Date: _____
Address: _____ Birthdate: _____
City: _____ Postal Code: _____ Phone Number: _____
Business Number: _____
Who referred you? _____ E-Mail: _____
Primary Physician: _____ Emergency Contact: _____
Physician Phone Number: _____ Emergency Contact #: _____

Other Health Care Practitioners: Chiropractor Physiotherapist Naturopath Other: _____
General Health Status: POOR FAIR GOOD EXCELLENT
Occupation: _____ Recreational Activities: _____
Primary Occupation Activities: _____
Primary Complaint: _____
Pain Scale: 0 1 2 3 4 5 6 7 8 9 10
(0 = no pain, 10 = most pain ever experienced)

HEALTH HISTORY

☑ Please indicate all current/ongoing (C/O) and past conditions you have experienced

Head/Neck	**C/O**	**Past**	**Respiratory/Lungs**	**C/O**	**Past**	**Digestive**	**C/O**	**Past**
Whiplash	☐	☐	Asthma	☐	☐	Constipation	☐	☐
Headaches	☐	☐	Bronchitis	☐	☐	Diarrhea	☐	☐
Migraine	☐	☐	Emphysema	☐	☐	Crohn's Disease	☐	☐
Concussion	☐	☐	Pneumonia	☐	☐	Irritable Bowel Syndrome	☐	☐
Ringing in the Ears	☐	☐	Shortness of Breath	☐	☐	Ulcers	☐	☐
Hearing Loss	☐	☐	Sinusitis	☐	☐	Diverticulitis	☐	☐
Vision Problems	☐	☐	Frequent Colds	☐	☐	Nausea	☐	☐
Brain Injury	☐	☐	Recurrent Lung Infection	☐	☐			
TMJ (Jaw Pain)	☐	☐	Chronic Cough	☐	☐			

Other: _____ Family History of Above: _____ Other: _____
Other: _____

Cardiovascular	**C/O**	**Past**	**Nervous System**	**C/O**	**Past**	**Infections**	**C/O**	**Past**
High Blood Pressure ___/___	☐	☐	Spinal Cord Injury	☐	☐	Hepatitis	☐	☐
Low Blood Pressure ___/___	☐	☐	Numbness/Tingling	☐	☐	Type: _____		
Heart Attack	☐	☐	Sensory Change/Loss	☐	☐	Infectious Skin	☐	☐
Chronic Congestive Heart Failure	☐	☐	Sciatica	☐	☐	Conditions	☐	☐
Chest Pain/Angina	☐	☐	Thoracic Outlet Syndrome	☐	☐	TB	☐	☐
Stroke	☐	☐	Seizures	☐	☐	HIV	☐	☐
Pace Maker or Similar Device	☐	☐	Multiple Sclerosis	☐	☐			
Phlebitis	☐	☐	Cerebral Palsy	☐	☐			
Hemophilia	☐	☐	Epilepsy	☐	☐			
Heart Disease	☐	☐	Carpal Tunnel	☐	☐			
Poor Circulation	☐	☐	Muscular Dystrophy	☐	☐			
Congestive Heart Failure	☐	☐						

Family History of Above: _____
Other: _____ Other: _____ Other: _____

Disease/Condition	C/O	Past	Skin	C/O	Past	Bone/Joint	C/O	Past
Cancer Benign/Malignant	☐	☐	Eczema	☐	☐	Dislocation	☐	☐
Type/Location: _____			Dermatitis	☐	☐	Fracture	☐	☐
Treatment: _____			Acne	☐	☐	Arthritis (RA/OA)	☐	☐
Fibromyalgia	☐	☐	Frostbite	☐	☐	Family History of Arthritis: _____		
Chronic Fatigue Syndrome	☐	☐	Psoriasis	☐	☐	Degenerative Disc Disease	☐	☐
Allergies	☐	☐	Sensitive Skin	☐	☐			
Diabetes (Type?) _____			Rash/Eruptions	☐	☐	Prolapsed/Herniated Disc	☐	☐
Onset: _____			Cold Sores	☐	☐			
			Herpes	☐	☐			
Other: _____			Other: _____			Other: _____		

Soft Tissue Joint Discomfort or Pain	C/O	Past
Head/Jaw	☐	☐
Neck	☐	☐
Shoulder	☐	☐
Arm	☐	☐
Wrist/Hand	☐	☐
Back	☐	☐
Hips	☐	☐
Legs	☐	☐
Knees	☐	☐
Ankles/Feet	☐	☐
Tendonitis	☐	☐
Strain/Sprain	☐	☐
Poor Posture	☐	☐

Other: _____

Women Only	C/O	Past
Pregnancy	☐	☐
Vaginal Birth/Abortion	☐	☐

Weeks Pregnant: _____

# of Children (not including this pregnancy) _____

Other: _____

Current medication or supplements and what condition do your medicine/supplements treat: _____

_____

Surgical operations or Hospitalizations (please indicate date of occurrence): _____

_____

Major injuries/accidents including fractures (please indicate date of occurrence): _____

_____

Of special note: (pins, wires, plates, artificial joints, etc.) Please explain: _____

_____

List any areas that you do **NOT** want treated: _____

Are you physically active? Yes ☐ No ☐

How often and Type? _____

Previous Massage Experience Yes ☐ No ☐

Good Sleeping Habits Yes ☐ No ☐

Regular Eating Habits Yes ☐ No ☐

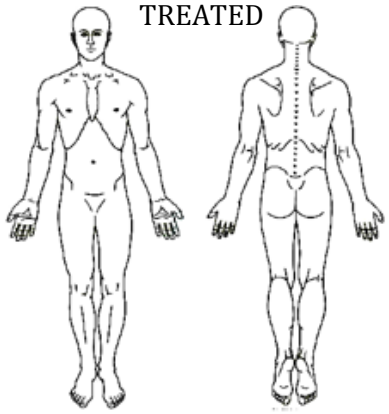
Stress Levels High ☐ Medium ☐ Low ☐

Date: _____

Client Signature: _____

Therapist Signature: _____

PLEASE CIRCLE CURRENT SYMPTOMATIC AREAS YOU WANT TREATED



Client Contract and Informed Consent

Jennifer Pullen, RMT

The following is a contract that you, the client is asked to sign as an informed consent. The contract is for you to fully understand your rights for the treatment and responsibility as a client.

It is important for you to let your therapist know of any changes to your health history, so that it may be updated. It is your right as the client to terminate the massage treatment at any time if you feel it is necessary. The therapist also has the right to terminate the massage treatment at any time.

During your initial visit you can expect to receive a series of tests. You will be receiving a **Postural Analysis** to determine sources of discomfort in order to identify if there are any discrepancies in your posture that may be causing pain. You may also receive **Range of Motion Testing** to see which ranges are affected by pain or not.

You could receive a variety of **Orthopedic Tests** during your treatment. These are done to differentiate between specific conditions or injuries.

During your massage treatment the therapist will only be undraping one body part at a time, that being the body part being treated. If at any time the therapist feels that Massage Therapy treatment will be beneficial on an area of sensitivity (i.e. Gluteal), the therapist will ask for specific and separate consent before proceeding.

Please list any sensitivities you may have that will affect your massage (i.e. scents, positions, lotions, etc.) _____

There will be a $30 charge for any missed appointments (without a 24hr notice of cancellation) and a $15 charge for any NSF cheques.

I _____ have read and fully understand the contract set out and give my consent for a treatment by Jennifer Pullen, RMT for massage therapy.

_____ _____

Signature: Date:

_____ _____

Therapist Signature: Jennifer Pullen, RMT Date: