RMT new patient in Limitless Health Clinic

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.

Name: ______________________ Phone # ______________

Address: ______________________

Occupation: ______________________ Date of Birth: ______________

Have you received massage therapy before? ☐ Yes ☐ No

Did a health care practitioner refer you for massage therapy? ☐ Yes ☐ No

If yes, please provide their name and address. ______________________

____

Please indicate conditions you are experiencing or have experienced:

Cardiovascular

- ☐ high blood pressure
- ☐ low blood pressure
- ☐ chronic congestive heart failure
- ☐ heart attack
- ☐ phlebitis / varicose veins
- ☐ stroke/CVA
- ☐ pacemaker or similar device
- ☐ heart disease

is there a family history of any of the above? ☐ Yes ☐ No

Respiratory

- ☐ chronic cough
- ☐ shortness of breath
- ☐ bronchitis
- ☐ asthma
- ☐ emphysema

is there a family history of any of the above? ☐ Yes ☐ No

Infections

- ☐ hepatitis
- ☐ skin conditions
- ☐ TB
- ☐ HIV
- ☐ herpes

Other Conditions

- ☐ loss of sensation, where? ______________
- ☐ diabetes, onset: ______________
- ☐ allergies/hypersensitivity to what? ______________

  type of reaction: ______________
- ☐ epilepsy
- ☐ cancer, where? ______________
- ☐ skin conditions, what? ______________
- ☐ arthritis

is there a family history of arthritis? ☐ Yes ☐ No

Head/Neck

- ☐ history of headaches
- ☐ history of migraines
- ☐ vision problems
- ☐ vision loss
- ☐ ear problems
- ☐ hearing loss

Women

- ☐ pregnant, due: ______________
- ☐ gynaecological conditions, what? ______________

Overall, how is your general health?

____

Primary Care Physician:

____

Address:

____

____

Current Medications:

____

condition it treats: ______________________

____

Are you currently receiving treatment from another health care professional? ☐ Yes ☐ No

If yes, for what? ______________________

____

Surgery – date ______________________

nature: ______________________

Injury – date ______________________

nature: ______________________

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

what? ______________________

Do you have any internal pins, wires, artificial joints or special equipment ? ☐ Yes ☐ No

what? ______________________

where? ______________________

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

____

____

____

Notes:

Date of initial Health History: ______________

Update 1 ______________

Update 2 ______________

Update 3 ______________

Update 4 ______________

CONSENT TO TREATMENT

I,______________________________________, consent to massage therapy

treatment as outlined by therapist________________.

Further,

It is my choice to receive a treatment. It is my understanding that all information I have provide to my therapist both in writing and verbally is confidential, and will not be released without my express permission.

I agree to communicate with my therapist any time I feel that my well being is being comprised, and I acknowledge that I may terminate treatment at any time.

I understand and accept possible risks and side effects from treatment, and my therapist has explained the consequences of having or not having treatment.

I have been informed that treatment provide by this office are not covered under the Ontario Health Insurance Plan and accordingly, I hereby agree to pay any account to the office at the conclusion of each and every visit.

Signature:__________________________________ Date:______________

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Treatment Plan for: ______________________________ Date: ____________

Limitations of activities of daily living:

Treatment plan discussed with Client:
Yes No

Clients Goal / Treatment Goal:

Received informed consent for treatment plan: Yes No

Type / Focus of treatment:

Frequency: ________________________ Duration: ________________

Areas to be treated:

back
neck
shoulders
face

arm L R
leg L R
gluteus
abdominals

chest
breast
other (list)

Assessments Performed:

Results of Assessments:

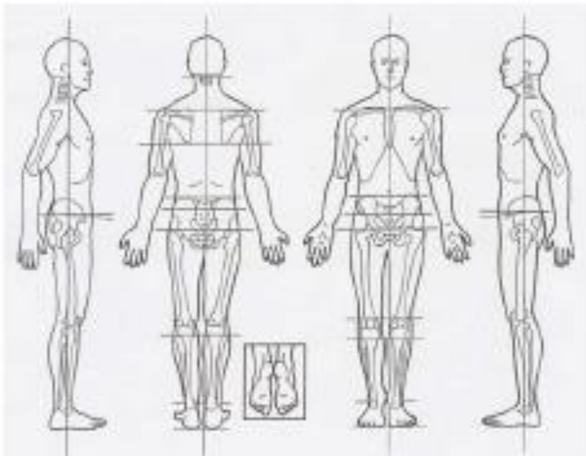
Reassessment schedule:

Anticipated Progression of Responses:

Remedial exercises/ Hydrotherapy recommended:

Contraindications / Risks:

Referrals:



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Treatment notes for: ____

Date:______________ Time:__________am pm Duration:____________min./hr. Fee $______

Informed consent received: treatment assessment Therapist: ____________________

Techniques Used:

☐ Swedish ☐ frictions ☐ deep facial ☐ trigger points ☐ stretch ☐ intra-oral

☐ breast massage ☐ hydrotherapy ☐ joint mobilization grade: _____ ☐ other (list) ____________________

Areas Treated:

☐ back ☐ neck ☐ shoulders ☐ face ☐ arm L R ☐ leg L R

☐ hip area ☐ abdominals ☐ chest ☐ breast ☐ other (list) ____________________

Clinical findings:

____

____

Clients reaction / feedback:

____

____

Recommended Self-Care:

____

____

Date:______________ Time:__________am pm Duration:____________min./hr. Fee $______

Informed consent received: treatment assessment Therapist: ____________________

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Clinical findings:

____

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Clients reaction / feedback:

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____

Recommended Self-Care:

____

____

Date:______________ Time:__________am pm Duration:____________min./hr. Fee $______

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Clinical findings:

____

____

Clients reaction / feedback:

____

____

Recommended Self-Care:

____

____