



Registered Massage Therapists'  
Association of Ontario

## HEALTH HISTORY

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 confidential unless allowed or required by law. Your written permission will be required to release any information

Name:		Date of Birth:	
Address:			
City:		Province:	Postal Code:
Home Phone:	Work Phone:		Cell Phone:
Email:		Preferred Method of Contact:	
Occupation:			
Have you received massage therapy before? <input type="checkbox"/> Yes <input type="checkbox"/> No			
Did a health care practitioner refer you for massage therapy? <input type="checkbox"/> Yes <input type="checkbox"/> No			
If yes, please provide their name and phone number:			
Family physician name, address, and phone number:			
Have you received treatment from another health care professional in the past year? <input type="checkbox"/> Yes <input type="checkbox"/> No			
If yes, please provide type of treatment (chiropractic, physiotherapy, etc):			
Emergency Contact:		Phone:	
Do you have extended health care benefits? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, company name:			
Primary Complaint:			
Injuries:		Date of occurrence:	
Were these injuries sustained as a result of a motor vehicle accident? <input type="checkbox"/> Yes <input type="checkbox"/> No			
Were these injuries sustained at work? <input type="checkbox"/> Yes <input type="checkbox"/> No			
Please list all surgeries and dates:			
Please list all current medications and conditions they are treating:			



**Please indicate conditions you are experiencing or have experienced:**

**Cardiovascular:**

- High Blood Pressure
- Low Blood Pressure
- Chronic Congestive Heart Failure
- Heart Attack
- Heart Disease
- Heart Palpitations
- Heart Murmur
- Stroke / CVA
- Aneurism
- Angina
- Blood Clots
- Raynaud's Disease
- Phlebitis / Varicose Veins
- Poor Circulation
- Pacemaker or Similar Device

**Respiratory:**

- Chronic Cough
  - Shortness of Breath
  - Bronchitis
  - Asthma
  - Emphysema
  - Pneumonia
  - Tuberculosis
  - Sinusitis
  - Sinus Congestion
- Do you smoke?  Yes  No

**Blood:**

- Anaemia
- Haemophilia
- Leukemia
- Hepatitis A B C

**Lifestyle:**

- Regular Exercise  
 Yes  Mostly  No
- Drink Plenty of Water  
 Yes  Mostly  No
- 8 Hours of Sleep Nightly  
 Yes  Mostly  No
- Good Eating Habits  
 Yes  Mostly  No

**Gastrointestinal:**

- Constipation
- Diarrhea
- Gas / Bloating
- Nausea / Vomiting
- Irritable Bowel Syndrome
- Crohn's / Colitis
- Hernia
- Ulcers
- Gall Bladder Problems
- Liver Problems
- Kidney Infections
- Bladder Infections
- Urination Problems
- Poor Appetite
- Excessive Thirst

**Skin:**

- Allergies:
  - Hypersensitivity
  - Bruises Easily
  - Rashes
  - Eczema
  - Psoriasis
  - Athletes Foot
  - Herpes
  - Warts
- Skin Conditions:

**Women:**

- Pregnant, Due:
- Infertility
- Menstrual Concerns / Pain
- Menopausal Concerns
- Endometriosis
- Fibroids
- Hysterectomy
- Vaginal Pain / Infection

**General Health:**

- Good  Fair  Poor

**Other (please list):**

**Head / Neck:**

- Headaches
- Migraines
- Whiplash
- Jaw Pain
- Ear Pain
- Hearing Problems
- Hearing Loss
- Vision Problems
- Vision Loss

**Muscle / Joint:**

- Muscle Strain
- Ligament Sprain
- Spasms / Cramps
- Tendinitis
- Bursitis
- Fibromyalgia
- Ankylosing Spondylitis
- Arthritis OA RA
- Osteoporosis
- Herniated Disc
- Degenerative Discs
- Joint or Bone Disease
- Scoliosis
- Dislocation
- Fracture

**Other Conditions:**

- Diabetes, onset:
- HIV / AIDS
- Cancer  
Type?
- Multiple Sclerosis
- Epilepsy
- Thyroid Disorders
- Lupus
- Loss of Sensation  
Where?
- Insomnia / Fatigue
- Fainting / Dizziness
- Anxiety / Nervousness
- Depression
- Alcohol / Drug Addiction

Is there a family history of any of the conditions listed above?

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

If yes, where?



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**Please ensure you read the following information in its entirety.**

I have read the above information and have stated all my previous and current medical conditions. I will update the Registered Massage Therapist regarding any updates in my condition as soon as possible.

In order to provide treatment, this clinic must collect personal health information. I understand that all information that I provide will be kept confidential unless allowed or required by law. I understand that I will be asked for written authorization before this information can be released.

I understand the 24 hour cancellation policy and agree to pay the missed appointment fee if I cancel within the 24 hour period preceding my appointment time. I understand that I am responsible to pay for the time reserved with the Registered Massage Therapist; regardless of the time I arrive and am ready for my appointment. I understand that this time will include intake, assessment, treatment, self-care recommendations, charting and administration. I understand that payment in full is due on the day of treatment.

Signature: \_\_\_\_\_

Date: \_\_\_\_\_

Permission to verify information on issued receipt with patient's insurer? Yes  NO

**Chart for Registered Massage Therapist's Use Only**

