Registered Massage Therapists' Association of Ontario

HEALTH HISTORY

The information requested below will assist us in treating you safely. Please 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 permission will be required to release any information, and you have the right to give, withhold or withdraw your consent to collect, use or disclose any personal health information at any time.

PATIENT INFORMATION		
Name:	Date of Birth:	
Address:		
City:	Province:	Postal Code:
Home Phone:	Work Phone:	Cell Phone:
Email:	Preferred Method of Contact:	
Gender:	Pronouns:	
Occupation:		
Accessibility needs:		
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:		
Family physician name, phone number and address:		
Have you received treatment from another health care professional in the past year? ☐ Yes ☐ No If yes, please provide type of treatment (chiropractic, physiotherapy, naturopath, etc.):		
Emergency Contact:	Phone:	
INSURANCE COVERAGE (If Applicable) - Optional		
Do you have extended health care benefits? ☐ Yes ☐ No		
Insurance company name:		
Policy Number:	Group Plan Number:	

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GENERAL HEALTH INFORMATION
Primary reason(s) for seeking massage therapy:
Do you have any allergies? ☐ Yes ☐ No If yes, list your allergies, and indicate whether they require an epi-pen:
Please list any recent/current injuries, and dates of occurrence:
Were these injuries sustained as a result of a motor vehicle accident? ☐ Yes ☐ No
Were these injuries sustained at work? ☐ Yes ☐ No
Please list all surgeries and dates:
List any health issues you have related to the following categories that may impact your massage therapy care. Muscle, joint or bone issues (e.g. arthritis, muscle strain): Heart or circulation concerns (e.g. high blood pressure): Lung or breathing issues (e.g. asthma): Neurological symptoms or conditions (e.g. dizziness, numbness, epilepsy/seizures, stroke, multiple sclerosis): Skin conditions that may impact your reaction to treatment (e.g. bruise easily, eczema, rashes): Gynecological concerns (e.g. pregnancy, menstrual concerns, menopause): Other conditions that may impact your massage therapy care:

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Are you taking any medications or substances that may affect your sensitivity, healing, or ability to receive massage (e.g., blood thinners, corticosteroids, pain medications, recreational drugs)?

☐ Yes ☐ No

If yes, please provide more information:

Are you experiencing any of the following symptoms: chronic pain, fatigue, tension, swelling, numbness, or inflammation?

☐ Yes ☐ No

If yes, please describe:

OPTIONAL HEALTH DISCLOSURES

Cancer Treatment History:

Have you been diagnosed with cancer or received or are currently receiving cancer treatment (e.g., chemotherapy, surgery, radiation)?

☐ Yes ☐ No

If yes, please describe any symptoms this may be causing you, as massage therapy can help address many of the symptoms related to cancer and cancer treatments:

Physical Symptoms Related to Mental Health (e.g., stress, anxiety, depression):

Mental health concerns can contribute to physical symptoms such as musculoskeletal pain, and many of these physical symptoms can be addressed by massage therapy. Are you experiencing physical symptoms such as fatigue, tension, or sleep disturbances that may relate to mental health?

☐ Yes ☐ No

If yes, please describe:

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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