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Natural Health Practitioners of Canada
Praticiens de la Santé Naturelle du Canada

Confidential

Massage Therapy Client Intake and Health History Form

The information you provide will assist the therapist in treating you safely and will be kept confidential unless allowed or required by law.

Contact and Personal Information

Name: _____

Address: _____

City: _____ Province: _____ Postal Code: _____

Phone: (w) _____ (h) _____ (cell) _____

Email: _____ Birthday(dd/mm/yy): ____ / ____ / ____

Occupation: _____

Emergency Contact: _____ Phone: _____

Were you referred by anyone? _____

Health History

Are you receiving treatments from other health-care professionals? Yes ☐ No ☐

If yes, what? _____

Family doctor's name and phone: _____

List any sports activities or hobbies: _____

Have you had massage treatments before? Yes ☐ No ☐

What is the reason you are seeking massage therapy?

_____

Are you on any medications or supplements? ☐ No ☐ Yes

If yes, please list and explain for what condition(s):

_____

Overall, how is your health? _____

Please indicate if you presently or previously had any of the following symptoms or ailments:

Cardiovascular

High blood pressure	☐	Phlebitis/varicose veins	☐
Low blood pressure	☐	Stroke/CVA	☐
Chronic congestive heart failure	☐	Pacemaker	☐
		Heart disease	☐

Family history of any cardiovascular difficulties? Yes ☐ No ☐

Respiratory

Chronic cough ☐
Shortness of breath ☐
Bronchitis ☐
Emphysema ☐
Asthma ☐

Family history of respiratory difficulties? Yes ☐ No ☐

Infections

Hepatitis ☐
Skin conditions ☐
TB ☐
HIV ☐
Herpes ☐

Head and Neck

Headaches ☐
Migraines ☐
Vision problems/loss ☐
Ear problems/hearing loss ☐

Other Conditions

Digestive disorders ☐
Diabetes ☐ Type 1 or 2?_____ On insulin? ☐
Allergies/hypersensitivity reactions ☐ To what? _____
Type of reaction?_____
Epilepsy ☐
Cancer ☐ Where?_____
Kidney disease ☐
Liver disease ☐
Skin problems ☐ What?_____
Dizziness ☐
Psychological/mental illness ☐
Arthritis ☐
Loss of sensation ☐ Where?_____

Women

Pregnant ☐ Due date:_____
Gynaecological conditions ☐ What?_____

Have you had surgery in the past 5 years? Yes ☐ No ☐

What was the surgery for? When?

_____

List any medical implants (pacemaker, pins, wires, artificial joints or special equipment)

_____

Have you had any accidents, injuries, or trauma in the past 5 years? Yes ☐ No ☐

If yes, please describe what happened:

_____

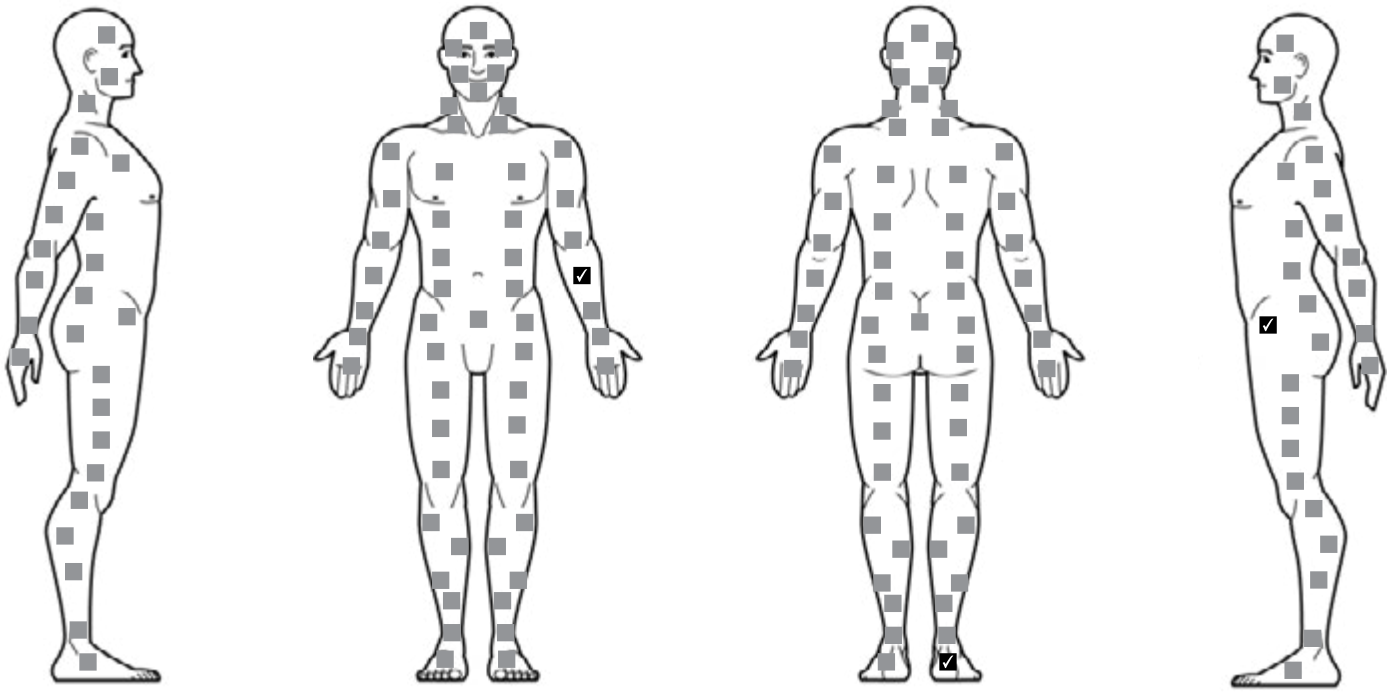
Do you have difficulty: Lying on your back? Yes ☐ No ☐
Lying on your front? Yes ☐ No ☐

Describe any other diagnosed diseases, medical conditions or health concerns your Massage Therapist should be aware of:

_____

_____

PLEASE CHECK (CLICK) AREAS OF DISCOMFORT



Massage Therapy Informed Consent

I have informed the Massage Therapist of all my known physical/medial conditions and medications. I will keep the Massage Therapist updated on any changes to my health history.

The Massage Therapist explained to me and I understand:

- why a health history is needed before massage begins
- that I may ask questions about the information being requested and my therapy at any time
- that all client information is confidential and written authorization will be obtained prior to release of information to other caregivers
- the general benefits of the massage treatment, possible massage contraindications and precautions
- the assessment and treatment procedures, techniques, and remedial exercises employed
- the body areas to be massaged
- that draping will be used to expose only those areas that require treatment
- that at any time, I may withdraw my consent and treatment will be stopped
- the duration and cost of the massage therapy treatment
- that massage therapy is not a substitute for medical treatment or medications
- that it is recommended that I work with my Primary Caregiver for any condition I may have
- that a Massage Therapist does not diagnose illness or disease and does not prescribe medications

I _____, have read, understood and completed, to the best of my knowledge, the Massage Therapy Client History form and the Massage Therapy Informed Consent form. I release the Massage Therapist from any and all liability from problems arising from the treatment as a result of information not given or incorrectly given in this client history form.

Client/Guardian Signature:_____ **Date:**_____

Practitioner Signature:_____ **Date:**_____

May we contact you via: phone ☐ email ☐ text ☐

Date of Initial Health History:_____

Update 1: _____ Update 2:_____ Update 3:_____ Update 4:_____