Baden Integrative Health

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 Email: _____
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_____

Massage Therapy Waiver and Consent Form

I understand that the massage I receive is provided for the basic purpose of relaxation, stress reduction, and/or relief of muscular tension within the scope of practice as defined by the College of Massage Therapists of Ontario.

I further understand that the massage should not be construed as a substitute for medical examination, diagnosis, or treatment and that I should see a physician, chiropractor, or other qualified medical specialist for any mental or physical ailments that I am aware of.

I understand that massage therapists are not qualified to perform skeletal adjustments, diagnose and/ or prescribe, and that nothing said in the course of the session should be construed as such.

Because massage is contraindicated under certain conditions, I affirm that I have stated all my known medical conditions and answered all questions honestly. I agree to keep the therapist updated as to any changes in my medical profile and understand that there shall be no liability on the therapist's part should I forget to do so.

I have read the above noted consent and have had the opportunity to question the contents. By signing this form, I confirm consent to treatment and such additional treatments as proposed by my therapist from time to time to deal with my physical condition for which I have sough treatment. I understand that at any time I may withdraw my consent and treatment will be stopped.

Name (Please Print): _____

Signature: _____

Missed/ Cancellation Appointment Policy

The office requires 24-hour notice for cancellation of Massage Therapy Appointments. Appointments missed or cancelled without sufficient notice will be charged the cost of the treatment.

I have read, understood, and agreed to the fees and payment obligations as indicated.

Patient (or parent/guardian) Signature: _____

Date: _____