Brampton Registered Massage Therapy Clinic

MEDICAL HISTORY FORM: FOR MASSAGE OR ACUPUNCTURE

**PLEASE COMPLETE THIS FORM IN FULL (4 PAGES).
AN ACCURATE HEALTH HISTORY IS IMPORTANT TO ENSURE THAT IT IS SAFE FOR YOU TO RECEIVE THERAPEUTIC TREATMENT.
ALL INFORMATION IS STRICTLY CONFIDENTIAL. PLEASE PRINT.**

Date: ______________________________

Name: ______________________________

Resident Address: ______________________________

______________________ Postal Code: ______________

Telephone Numbers: Home #: ______________________

Work #: ______________________

Cell #: ______________________

Occupation: ______________________________

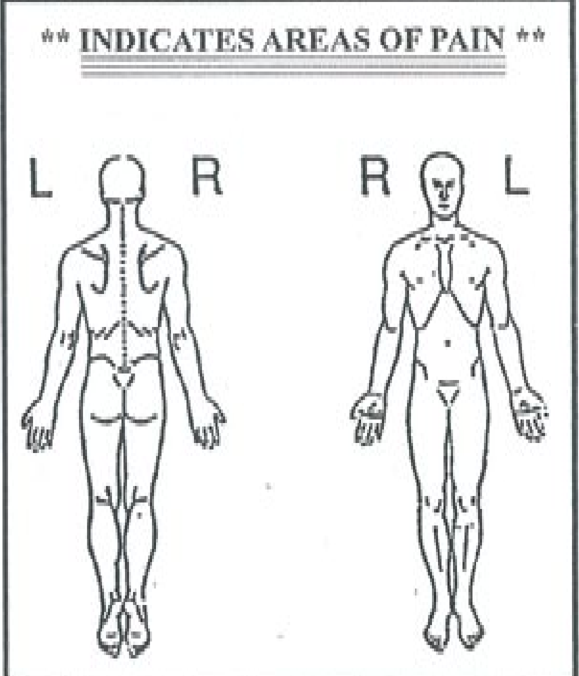
May we contact you at work: ☐ Yes ☐ No

Birthdate: ______________________________

Sex: Male / Female

Marital Status: ______________________ Children: yes / no

Personal Physician: ______________________________



Physician's Telephone #: ______________________ Physician's Address: ______________________

Date of Last Medical: ______________________ ______________________

List all past surgeries, injuries / accidents/fractures and dates occurred:

____

____

____

PLEASE LIST ALL MEDICATIONS YOU ARE CURRENTLY TAKING, OR HAVE TAKEN WITHIN THE LAST 6 MONTHS:

____
(Medication and reason for taking)

____
(Medication and reason for taking)

____
(Medication and reason for taking)

____
(Medication and reason for taking)

Date of Initial Health History: ______
Update 1 ______
Update 2 ______
Update 3 ______
Update 4 ______
Update 5 ______
Update 6 ______
Update 7 ______
Update 8 ______
Update 9 ______
Update 10 ______
Please date & initial

ONLY CHECK ANY PAST OR CURRENT HEALTH CONDITIONS:

RESPIRATORY

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

CARDIOVASCULAR

___ Severe high blood pressure
___ Low blood pressure
___ CCHF
___ Heart attack (History of Myocardial Infarction)
___ Phlebitis
___ Stroke/Post Cerebrovascular Accident
___ Pacemaker or similar device
___ Heart disease
___ Aneurysms
___ Hardening of the Arteries

SKIN

___ Skin conditions
___ Local irritable skin conditions

INFECTIONS

___ Contagious or Infectious conditions e.g. Warts
___ Do you have any infectious conditions such as: Tuberculosis, AID/HIV, Hepatitis A/B/C/, TB, Influenza, SARS
If yes, please explain: ____________________

HEAD/NECK

___ Vision problems
___ Vision loss
___ Ear problems
___ Hearing loss

OTHER CONDITIONS

___ Loss of sensations
___ Diabetes (onset: ____________)
___ Allergies (i.e. anaphylaxis or skin irritation)
(If yes, please list ________________________________)
___ Epilepsy
___ Cancer
___ Undiagnosed Lump
___ Gout
___ Ankylosing Spondylitis
___ Osteoarthritis
___ Osteoporosis
___ Rheumatoid Arthritis
___ Systemic Lupus Erythematosus
___ Fibromyalgia
___ Reiter's Syndrome
___ Joint Instability/Hypermobility
___ Scleroderma
___ Polymyalgia
___ Acute Inflammatory Condition
___ Hernia
___ Chronic Abdominal/Digestive Disease
___ Endometriosis
___ Pelvic Inflammatory Disease
___ Blood conditions including Hemophilia
___ Anemia
___ Flaccid Paralysis
___ Chronic or Long Standing Thrombosis
___ Phlebitis (Swollen vein)
___ Arteritis (Swollen artery)
___ Severe Varicose Veins
___ Neuritis (Swollen nerve)
___ Multiple Sclerosis
___ Buerger's Disease
___ Chronic Kidney Disease
___ Immunological Disease
___ Alcohol or Drug Addition

Other (Please list)________________________________

ONLY CHECK IF YOU HAVE EVER EXPERIENCED ANY OF THE FOLLOWING, EVEN SHORT OR TEMPORARY ATTACKS:

___ Swollen joints
___ Bruise easily
___ Fainting
___ Breathing Difficulty
___ High blood pressure
___ Dizziness
___ Chest pain
___ Rapid Heart Beat
___ Poor circulation
___ Slurred speech
___ Temporary lack of understanding
___ Sudden collapse without Loss of Consciousness

___ Diminished or Partial Loss of Vision in Both Eyes
___ Hearing loss in One or Both Ears
___ Difficulty Swallowing
___ Numbness or Loss of Sensation in the:
  ___ Face ___ Arms
  ___ Fingers ___ Legs
  ___ Hands ___ Other body parts ____________
___ Weakness, Clumsiness or Loss of Strength in the:
  ___ Face ___ Arms
  ___ Fingers ___ Legs
  ___ Hands
___ Loss of Consciousness, Even Momentary Blackouts

Do you exercise regularly? (ie. 2 or 3 times per week?) Yes / No

DO YOU EXPERIENCE ANY OF THE FOLLOWING SYMPTOMS DURING OR SHORTLY AFTER PHYSICAL ACTIVITY, PLEASE CHECK:

___ Extreme muscle soreness
___ Extreme weakness / fatigue
___ Difficulty breathing
___ Abdominal discomfort
___ Headaches
___ Dizziness
___ Chest pains
___ Other (Please list) ______________________________

Are you pregnant? __________ If yes, what is your due date? ______________________

Do you have surgical implants such as pins, metal plates, pacemaker, other?
If yes, where?______________________________

LIST ANY OTHER HEALTH PROBLEMS NOT MENTIONED ON THIS FORM:

____

HOW WOULD YOU RATE YOUR GENERAL HEALTH STATUS? ______________________

ARE YOU CURRENTLY UNDERGOING ANY FORMS OF TREATMENT? Please list:
(e.g. Physiotherapy, chiropractic, acupuncture, etc.)

____

____

____

Have you ever experienced Massage Therapy? Yes / No
If "yes", did you suffer any adverse reactions? Yes / No
If "yes", explain______________________________

How did you find out about our clinic? ______________________________

WHAT IS YOUR MAIN PROBLEM THAT YOU WOULD LIKE TREATED TODAY?

____

____

I certify that the above information given on this form is true and accurately reflects my past and present health status. I will inform my Practitioner if I have any changes in my health or medications. I am aware that there is a 24 HOUR CANCELLATION POLICY & IF I DO NOT GIVE 24 HOURS NOTICED I WILL BE CHARGED FOR THE FULL FEE.

Patient's/Guardian Signature ______________________ **Date** ______________

Note: Our services are not covered by O.H.I.P. Please check your extended health care plan for coverage details.

HEALTH AND TREATMENT CONSENT FORM
FOR BRAMPTON REGISTERED MASSAGE THERAPY &/OR BRAMPTON ACUPUNCTURE

Note to Patient: We want your informed consent. This means that we want you to understand the services we hope to provide to you, the cost involved, and what we do with personal information we obtain from you. If you have a question on any of this, please ask.

CONSENT TO TREATMENT FORM

I, ________________________________ of my own free will consent to be treated for the following complaint(s):

____

____

I acknowledge that my Massage Therapist &/or Acupuncturist, Chiropractor, Osteopath has provided me with such information as is pertinent for treatment of the above listed complaint(s).
Alternative courses of treatment where applicable and relevant have been explained to me as well as the possible risks and side effects of my therapist's proposed treatment plan.
I understand fully the consequences of having treatment/not having treatment.
I appreciate that my consent herein provided, may be revoked at any time if I so choose.

In compliance with the "consent to Treatment Act" 1992, I provide my full Voluntary Informed consent to be treated by Linda Baird B.A., R.M.T. or Andy Baird B.A., D.Ac. or any one of the clinics associates'.

CONSENT FOR THE COST OF SERVICES

The therapist will review the costs of treatment effective today________________________________.

CONSENT FOR PERSONAL INFORMATION

I understand that to provide me with Massage Therapy &/or Acupuncture, Chiropractic, Osteopathic services, Brampton Registered Massage Therapy Clinic &/or Brampton Acupuncture & Herbal Medicine Clinic will collect some personal information about me (e.g. Telephone numbers to contact you, address health issues on our Health History form).

I have reviewed the Brampton Registered Massage Therapy Clinic and Brampton Acupuncture & Herbal Medicine Clinic's Privacy Policy about the collection, use and disclosure of personal information, steps taken to protect the information and my right to review my personal information. I understand how the Privacy Policy applies to me. I have been given a chance to ask any questions I have about the Privacy Policies and they have been answered to my satisfaction.

I understand that only if I check off the following spaces I will NOT receive any of the following:

____ I, **do not** want to receive notice when it is time to review whether I need new services.
____ I, **do not** want to receive notice of New modalities offered or changes withing the clinic e.g. New R.M.T's
____ I, **do not** want to receive newsletters and other informational mailings and notice of promotions or cards such as birthday, sympathy or general cards of caring.
____ I, **do not** want to receive a Thank you call for referring someone to the clinic.
____ I, **do not** give the clinic permission to call to thank the patient that referred me to the clinic (if applicable).
____ I, **do not** want a report &/or progress report sent to my referring Doctor (if applicable), this may contain information such as; what I presented with, type of treatment received, outcome of treatment, homecare assigned and a recommended treatment plan. A progress report may contain the above with added information on your progress.
____ I **do not** want (list what you would like to add) ________________________________

I understand that, as explained in the Policies and Procedures for personal information, there are some rare exceptions to these commitments.

I agree to Brampton Registered Massage Therapy Clinic &/or Brampton Acupuncture & Herbal Medicine Clinic using and disclosing personal information about me as set out above and in the Brampton Registered Massage Therapy Clinic &/or Brampton Acupuncture & Herbal Medicine Clinic's Privacy Policy.

SIGNATURE: ________________________ PRINTED NAME: ________________________

WITNESS: ________________________ DATE: ________________________

ADDITIONAL NOTES MADE BY THE PATIENT&/OR BRAMPTON REGISTERED MASSAGE THERAPY CLINIC &/OR BRAMPTON ACUPUNCTURE & HERBAL MEDICINE CLINIC. ________________________

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