HAMILTON BACK CLINIC

1600 Rymal Road East,
Hamilton, ON, Canada
905.692.4222 | 905.388.2022

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 of 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? ☐ Yes ☐ No

Did a health care practitioner refer you for massage therapy? ☐ Yes ☐ 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? ☐ Yes ☐ No

If yes, please provide type of treatment (chiropractic, physiotherapy, etc):

Emergency Contact:	Phone:

Do you have extended health care benefits? ☐ Yes ☐ No If yes, company name:

Primary Complaint:

Injuries:	Date 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:

Please list all current medications and conditions they are treating:

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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 Palpations
☐ 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

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:

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
☐ Fibromyalgia
☐ Ankylosing Spondylitis
☐ Arthritis OA RA
☐ Osteoporosis
☐ Herniated Disc
☐ Degenerative Discs
☐ Joint or Bone Disease
☐ Scoliosis
☐ Dislocation
☐ Fracture

Other Conditions:

Blood:
☐ Anaemia
☐ Haemophilia
☐ Leukemia
☐ Hepatitis A B C
Endometriosis

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

Women:
☐ Pregnant, Due:
☐ Infertility
☐ Menstrual Concerns / Pain
☐ Menopausal Concerns
☐ Epilepsy
☐ Fibroids
☐ Hysterectomy
☐ Vaginal Pain / Infection

General Health:
☐ Good ☐ Fair ☐ Poor

Other (please list):

☐ Diabetes, onset:
☐ HIV / AIDS
☐ Cancer
Type?
☐ Multiple Sclerosis
☐ 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 joint or special equipment? YES NO if yes where?____________________________

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BY SIGNING CONSENT, THE PATIENT AGREES TO THE FOLOWING:

1. All massage treatments, information and records will be kept confidential and securely stored for use only by massage therapist.
2. Written consent must be given by me prior to any disclosures or sharing of my personal and clinical information with any third party.
3. Privacy will be assured as I have the right to undress only to my comfort level and according to the requirements of the treatment.
4. Draping will be used by the therapist as required to expose only parts of my body the require treatment and or as I choose to ensure my comfort during treatment.
5. During treatment, the therapist will endeavor to work such that a pain level of 1-8is not exceeded, biased on a pain scale of 1’10.
6. If anytime during the treatment, I feel uncomfortable with the treatment for any reason, I have the right to request an immediate stop to the session or request modifications to the treatment, regardless of prior consent given.
7. Promptness is expected for all appointments. In the event of lateness, the massage may be cut short due to other commitments of the therapist. Fees will be maintained per the schedule
8. Cancellations of appointments must be received at LEAST 23 HOURS in advance. Other wise 100% of the appointment is due.
9. Fees for treatment are due prior to departure on the day of treatment. CASH, DEBIT, CREDIT are accepted.
10. The therapist may refuse to treat any client or part of their body with just and reasonable cause.

I ____, (PRINT NAME) have read and understand the information above and consent to the massage treatment for the condition discussed with my therapist today.

Date: ____

Patient signature: ____________________________________

Therapist ____________________________________

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RMT PRIVACY CONSENT FORM

I am aware that **this office** is keeping my personal information as outlined on the reverse of this page for the reasons disclosed. I am aware that the members of this staff of **this office** may access the information. I give my consent for this information to be collected and disclosed as outlined by me.

____________ my file may be used for quality adult purposes.

____________ you may consult other healthcare professionals about my case.

_____________ the office staff may look up my pertinent information for rescheduling purposes and or as deemed necessary.

Your privacy is our utmost concern.

Name _____________________________________ Signature ________________________

Date _____________________________________

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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 THERAPIST ONLY