Bellesmere Massage Therapy Clinic
HEALTH HISTORY FORM

Health History updated: _____ _____ _____ _____

Name: _____ Gender: ❑ female ❑ male Date: _____

Address: _____ City: _____ PC: _____ Email: _____

Home Phone: _____ Work Phone: _____ Cell Phone: _____

Date of Birth: _____ Height: _____ Weight: _____

Occupation: _____ Hobbies: _____

Where did you hear about the clinic? _____ General Health Status _____

What brings you in for a massage today? _____

Do you have insurance coverage for Massage Therapy? ❑ extended health benefit ❑ motor vehicle accident

HEALTH HISTORY: Please check the condition that you are currently experiencing, or have experienced in the past.

HEAD/NECK
Current Previous
- ❑ ❑ headaches: type_____
- ❑ ❑ vision problems
- ❑ ❑ hearing loss
- ❑ ❑ earaches
- ❑ ❑ other _____

RESPIRATORY
Current Previous
- ❑ ❑ chronic cough
- ❑ ❑ pneumonia
- ❑ ❑ shortness of breath
- ❑ ❑ smoking
- ❑ ❑ breathing disorders (ie: asthma, bronchitis, emphysema) type:_____
- ❑ ❑ sinus problems
- ❑ ❑ other _____

SKIN
Current Previous
- ❑ ❑ skin conditions: type_____
- ❑ ❑ bruise easily
- ❑ ❑ plantar warts
- ❑ ❑ other _____

INFECTIONS
Current Previous
- ❑ ❑ hepatitis
- ❑ ❑ tuberculosis (TB)
- ❑ ❑ HIV, AIDS
- ❑ ❑ other _____

WOMEN
Current Previous
- ❑ ❑ menstrual problems ❑ painful
- ❑ ❑ gynecological surgery type:_____
- ❑ ❑ pregnant - due date: _____
- ❑ ❑ children - number of_____
- ❑ ❑ menopausal problems
- ❑ ❑ other _____

CARDIOVASCULAR
Current Previous
- ❑ ❑ high blood pressure
- ❑ ❑ low blood pressure
- ❑ ❑ poor circulation
- ❑ ❑ heart disease/heart attack
- ❑ ❑ pacemaker
- ❑ ❑ chronic congestive heart failure
- ❑ ❑ phlebitis
- ❑ ❑ stroke - ❑ paralysis? _____
- ❑ ❑ varicose veins Doctor diagnosed? ❑ yes ❑ no
- ❑ ❑ other _____

OTHER CONDITIONS
Current Previous
- ❑ ❑ difficult digestion
- ❑ ❑ constipation
- ❑ ❑ crohn's disease or colitis
- ❑ ❑ ulcers - type: _____
- ❑ ❑ diabetes - onset _____ - insulin _____
- ❑ ❑ gallbladder _____
- ❑ ❑ kidney _____
- ❑ ❑ bladder _____
- ❑ ❑ liver _____
- ❑ ❑ allergies - food, hayfever etc. _____ _____
- ❑ ❑ loss of sensation: _____
- ❑ ❑ cancer - type:_____ where _____
- ❑ ❑ epilepsy
- ❑ ❑ multiple sclerosis
- ❑ ❑ parkinson's disease
- ❑ ❑ osteoporosis
- ❑ ❑ fibromyalgia
- ❑ ❑ chronic fatigue syndrome
- ❑ ❑ polio
- ❑ ❑ artificial joints/limbs/pins/wires
- ❑ ❑ use wheelchair/walker/cane etc.
- ❑ ❑ other _____

MEDICATIONS & CONDITIONS TREATED
_____ _____ _____ _____

VITAMIN SUPPLEMENTS
_____ _____ _____ _____

MEDICAL DOCTOR
Name: _____

Address: _____

Phone: _____

Date of last visit: _____

OTHER HEALTHCARE
Current Previous
- ❑ ❑ Massage
- ❑ ❑ Chiropractic
- ❑ ❑ Physiotherapy
- ❑ ❑ Exercise
- ❑ ❑ Nutritionist
- ❑ ❑ Naturopath
- ❑ ❑ Homeopath
- ❑ ❑ Psychotherapy
- ❑ ❑ Neurologist

Please see reverse for additional information.

❑ INFORMED CONSENT (To be checked by RMT)

MUSCULOSKELETAL

Current	Previous		Where & When
❑	❑	joint sprain	
❑	❑	muscle strain	
❑	❑	fracture	
❑	❑	dislocation	
❑	❑	whiplash	
❑	❑	low back pain	
❑	❑	scoliosis	
❑	❑	bursitis	
❑	❑	tendonitis	
❑	❑	carpal tunnel syndrome	
❑	❑	frozen shoulder	
❑	❑	flat feet	
❑	❑	sciatica	
❑	❑	arthritis	

- type: _____
- where: _____
- Doctor diagnosed? ❑ yes ❑ no
- family history: ❑ yes ❑ no

INJURY & SURGERY ie: motor vehicle accidents, falls, work and sport related injuries. Please include all injuries and surgeries, even if you may feel they are not relevant.

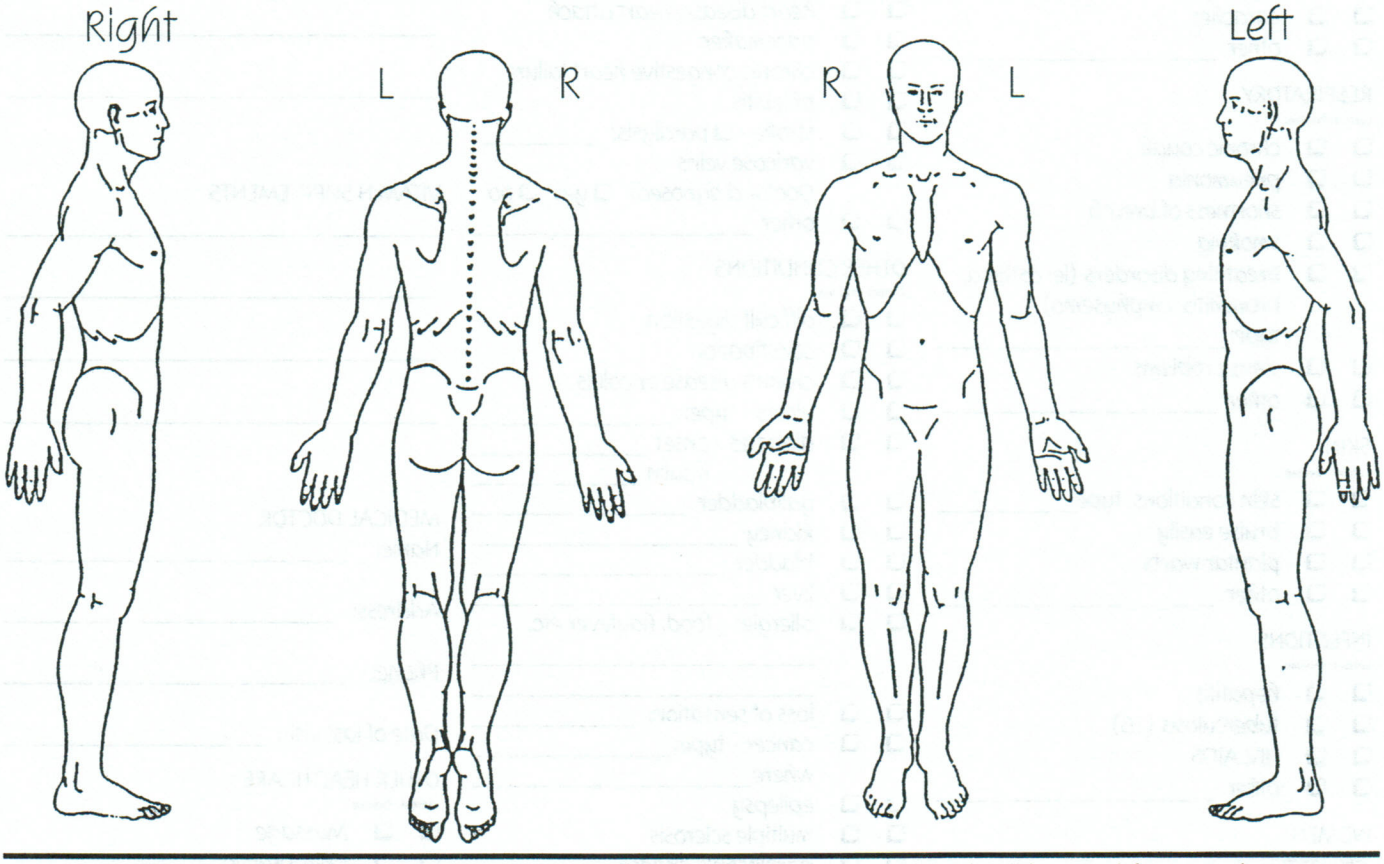
type: _____
date: _____
current symptoms: _____

type: _____
date: _____
current symptoms: _____

type: _____
date: _____
current symptoms: _____

type: _____
date: _____
current symptoms: _____

ON THE DIAGRAMS BELOW, PLEASE INDICATE WITH AN "X", ANY AREAS OF PAIN OR DISCOMFORT YOU ARE EXPERIENCING.



I understand that the information that I give on this form will be confidential and will be used for no other purpose than the professional therapist's records. I understand that I must give 24 hours notice of cancellation otherwise A MISSED APPOINTMENT FEE WILL BE CHARGED. If I was referred for Massage Therapy by another Health Care Professional, I hereby authorize my Registered Massage Therapist to discuss information regarding my records with that Health Care Professional.

Signature: _____ Date: _____

Bellesmere Massage Therapy Clinic Privacy Legislation Policy

1. The information Office for Bellesmere Massage Therapy is Janice McCord.

2. Only the information required to provide safe and effective massage therapy is collected. We ask for the clients home, work and cell phone numbers in order to notify of any changes of appointment times and cancellations. We can also forward information or receipts if need be.

3. All files are kept in a secure location for a minimum of 10 years from the last appointment date, as require by the RHPA. They are then shredded for disposal to maintain confidentiality of information.

4. Only the Therapist at Bellesmere Massage Therapy Clinic who is treating the client will access the information in the file. If the client was referred to Bellesmere Massage Therapy by another healthcare professional, the therapist may provide information, regarding treatment, to the referring healthcare provider. If the therapist at Bellesmere Massage Therapy refers the client to another healthcare professional, they may disclose information, regarding treatment to the healthcare provider. Clients may request, in writing, that their information is not to be disclosed with consulting healthcare providers. Client information will not be disclosed to any other sources. The Quality Assurance program of massage therapists of Massage Therapists requires that we are audited by a Peer Assesor once every 5 years. Clients may request in writing that their name be concealed for confidentiality, during the review.

5. By providing your email address, you agree to receive emails from Bellesmere Massage Therapy regarding any changes to the clinic or therapist services that we provide. You may unsubscribe at any time.

6. Clients have the right to see and read their files at any time upon providing 48 hours written request. The information Office will assist the client in understanding the file. The client can request changes to the personal information in the file if he/she believes it to be incorrect. In any case where the Information Officer and the client cannot agree on an amendment to the information, such disagreements may be taken to the Information and Privacy Commissioner who may review the situation. Bellesmere Massage Therapy reserves the right to request reasonable payment for and photocopies of information from the file that the client might request.

7. The Therapists at Bellesmere Massage Therapy Clinic assume consent to make reminder calls, or any other calls to our clients, including leaving voice mail messages at the client's home or work place unless otherwise advised by the client in writing.

I _____have read and agree to the above policies,

Dated _____ Signed _____