HEALTH HISTORY FORM

How did you hear about our clinic?

Yellow Pages______Website______Our sign______Facebook______Other?____________

Family/Friend/Co-Worker___WHO?__________________________________

Permission to acknowledge the person who referred you______________(Initials)

Name:____ Date:________________________
Address:_________________________________ Telephone:(Home)_____________________
City:_______________________Postal Code:______________ (Cell)______________________
(Work)______________________
Occupation:_____________________________ Company:_________________________________
Email Address:________________________________ Date of Birth(mm/dd/yy)_______________
Emergency Contact:________________________________ Telephone:_____________________

Do you have Extended Health Care Insurance Coverage for Massage Therapy? Yes No
Company Name:___________________________Policy Number:__________________________
Doctor's Name:_________________________________Telephone #:_________________________
Permission to consult with your Doctor: Yes No Initials: ______________________

Primary Complaint?_________________________Aggravates/Relieves?______________________
Have you seen a Doctor for this problem? Yes No When?____________________________

Please indicate conditions you are experiencing or have experienced:

Respiratory
- Chronic Cough
- Shortness of Breath
- Sinus Problems
- Emphysema
- Asthma
- Allergies
- Other________________

Cardiovascular
- High/Low Blood Pressure
- Blood Clots
- Heart Disease/Heart Failure
- Myocardial Infarction
- Stroke/CVA
- Pacemaker or similar device
- Other_________________

Digestive
- Constipation/Diarrhea
- Gas/Bloating
- IBS
- Other_______________

Nervous System
- Herpes/Shingles
- Numbness/Tingling
- Where?____________
- Chronic Pain
- Loss of Sensation
- Where?_____________
- Other_______________

Musculo-Skeletal
- Bone or Joint Disease
- Arthritis-Type______________
- Tendonitis
- Bursitis
- Sprains/Strains
- Low back/Hip/Leg pain
- Neck/Shoulder/Arm pain
- Jaw Pain/TMJ
- Other:_______________________

Reproductive
- Pregnant
- Due Date:___________
- Other:______________

Infections:
- Hepatitis
- TB
- HIV/AIDS
- Other:________________

Skin
- Allergies- ______________
- Allergy to creams/lotions
- Athletes Foot
- Warts
- Eczema/Psoriasis
- Other:__________________

Other
- Bruise Easily
- Depression
- Diabetes-Type________
- Vision/Hearing Loss
- CFS/Fibromyalgia
- Headaches/Migraines
- Cancer-_____________
- Epilepsy
- Kidney Disease_______ Other:_____

Please turn over and complete other side ⇒

Current Medications, Vitamins, Herbal Remedies & Conditions they treat:
Name:_______________________________ Condition:____
Name:_______________________________ Condition:____
Name:_______________________________ Condition:____
Name:_______________________________ Condition:____

Surgeries and Approximate Date:
Surgery:____ Date:_________________________
Surgery:____ Date:_________________________
Surgery:____ Date:_________________________

Motor Vehicle Accidents and Date
Accident & Injuries:_____________________________________ Date:_________________________
Accident & Injuries:_____________________________________ Date:_________________________

Other Accidents and Injuries:______________________________ Date:_________________________
Presence of Internal Pins, Wires, Artificial Joints, Special Equipment, Etc.:_____________________________

Other Therapies (Chiropractic, Physiotherapy etc.):____

Do you have any other conditions not listed or is there anything about yourself you feel would be important for your Massage Therapist to know:____

Please check the body parts you consent to be treated: Back______Head/Face______Neck______
Shoulders/Arms_____Hips______Legs______ Buttocks_____Abdomen_____Inner Thigh______

Consent Form:

It is important that you fill out this health history form to ensure that it is safe for you to receive Massage Therapy Treatment. If your health status changes please notify your therapist before your next treatment. All information gathered will be kept confidential except as required by law or to facilitate an assessment or treatment. Written authorization from you will be required before any information is released.

I agree to communicate with my massage therapist at any time if I have questions, if I feel uncomfortable, or if I feel my well-being is being compromised. I will give consent to my massage therapist to treat only on the areas of my body we discussed in the treatment plan. This may include sensitive areas such as gluteals/buttocks, breast/chest wall and upper inner thigh, if necessary. **Initials________________**

I am aware that I may remove only the clothing that I am comfortable removing. I know that I have the right to stop or modify the treatment at any time. It is my choice to receive massage therapy. I understand that Registered Massage Therapists do not diagnose illness, disease or any mental or physical disorder; nor do they prescribe medical treatment or pharmaceuticals. **Initials_______________**

Cancellation Policy: There is a $25.00 charge for the first missed appointment, or appointments cancelled with less than 24 hrs notice. There will be a full treatment charge for the 2nd and subsequent missed appointments. The 30-75 min. time slot is reserved specifically for you. If you are unable to keep your appointment please notify the office at least 24 hrs before your appointment to enable others to attend a treatment. If you are receiving treatment resulting from an automobile accident that is covered by an insurance claim, any missed appointments will be billed to you personally.

Signature:____ Date:_________________________
Parent/Guardian Signature:________________________________ Date:_________________________
(if under 16 years of age)

Permission Form:

I,____________________________________give permission for the clinic of Fort Erie Therapeutics. to send informational material via mail or email. Personal Information collected by the clinic will not be used for any other purposes. Yes No
My email address is:____
Signature:____Date:______________________________