Andrea Lorentz HonBA, RMT ◊ Massage Therapy Health History

WELCOME! I would like to make your appointment as pleasant & comfortable as possible. If at any time you have questions regarding your session, please let me know. If any of the following information changes at any time (health or contact info), please update me at your next visit.

Name _____ Date of Birth _____ Age ____
Address _____ City _____ Prov ____
Postal Code _____ Home Phone _____
Work Phone _____ Cell Phone _____
Email _____ Occupation _____

Referred by: □Queen-West Physio □Internet Search □Burford Times □Kijiji Ad □CMTO Website
□"*RMT Find*" Website □Yellow Pgs-ONLINE □Yellow Pgs-PRINT □Sign □Postcard
□Bulletin Board Business Card □Word of Mouth _____

Family Doctor _____ Address _____
Emergency Contact & Relationship _____ Phone _____

♦ Describe Main Complaint:

_____

♦ Have you received Massage Therapy before? □Yes □No Approx. last treatment? _____

♦ Regarding your Massage Therapy Treatment, what are your preferences regarding:
Pressure: □Light □Moderate □Deep Tissue
Conversation: □Silence □Minimal □Casual conversation

♦ Have you ever received Treatment by any of the following for this complaint?
□Massage Therapist □Medical Doctor □Physiotherapist
□Chiropractor □Osteopath □Other _____

♦ Current **Medications & Supplements** (Incl. over the counter drugs) & the condition it is taken for:
Name: _____ Condition: _____
Name: _____ Condition: _____
Name: _____ Condition: _____
Name: _____ Condition: _____
Name: _____ Condition: _____

♦ List all Surgeries/Major Infections(appendicitis, kidney infections), date occurred, current symptoms (if any):
1. _____ _____ _____
2. _____ _____ _____
3. _____ _____ _____

♦ List all Motor Vehicle Accidents, Major Injuries (fractures,sprains/strains,hernia) date occurred, current symptoms:
1. _____ _____ _____
2. _____ _____ _____
3. _____ _____ _____

OFFICE USE ONLY File Update: Date _____ Initals _____
Date _____ Initals _____
Date _____ Initals _____

♦ Check any of the following (current or previous) which apply to you:

Pain / Stiffness / Swelling

□Upper Back □Hip □Neck □Elbow □Tendonitis/Bursitis
□Mid Back □Knee □Shoulders □Wrist □Carpal Tunnel Syndrome
□Low Back □Ankle □Arm/Hand □Other _____

Head/Spine

□Headache: Frequency_____ Location_____ □Migraines
□Sciatica: left/right □Degenerated Disc(area)_____ □Herniated Disc(area)_____
□Fracture(area)_____ □Whiplash(yr)_____ □Pinched nerve(area)_____
□Pins,wires,artificial joints(area)_____ □Scoliosis (upper, mid, lower)

Respiratory

□Pneumonia □Bronchitis □COPD □Sinusitis □Shortness of Breath
□Emphysema □Asthma □Smoking □Other _____

Skin

□Psoriasis □Eczema □Warts □Plantar Warts □Bruise Easily
□Hemophilia □Loss of Sensation_____
□Contagious Conditions _____ □Skin Sensitivities/Allergies_____

Cardiovascular

□High Blood Pressure □Low Blood Pressure □Heart Attack(date)_____
□Stroke_____ □Pace Maker □Poor Circulation □Angina
□Diabetes □Phlebitis □Anemia □Deep Vein Thrombosis
□Congestive Heart Failure □Varicosities □Other _____

Digestive / Urinary

□Poor Digestion □Crohn's / Colitis □Irritable Bowel □Bladder □Ulcers
□Prostate □Constipation □Liver/Gall Bladder □Kidney

Infectious Diseases

□TB □Hepatitis___ □HIV/Aids □Herpes/Cold Sore □Other_____

Female

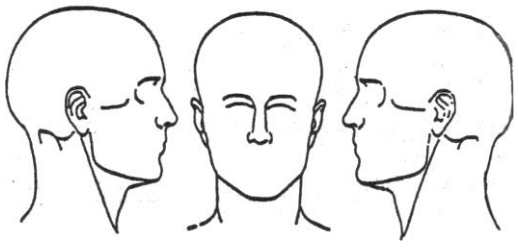
□Menstrual Cramps □Menopause □ C-Section □Natural Childbirth □Pregnant(due)_____

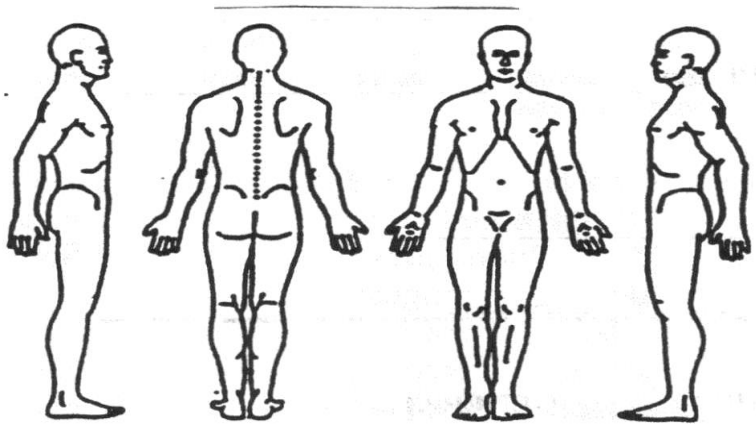
Other Conditions

□Osteoporosis □Cancer □Epilepsy □Fibromyalgia □Anxiety/Depression
□Multiple Sclerosis □Allergies _____ □Cerebral Palsy
□Arthritis Osteo / Rheumatoid(areas)_____

Additional Notes & Other Conditions, please elaborate:

Mark areas of pain, numbness/tingling, swelling, loss of movement:





Andrea Lorentz HonBA, RMT ◊ Informed Consent for Treatment

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- Being that massage should not be done under certain medical conditions, I _____ hereby declare that all medical and personal information is correct, and agree to keep the therapist updated as to any changes.

- □ _____ (check & initial) I give consent to contact any of my other medical practitioners if necessary, to clarify or add to any health information including diagnostic tests.

- □ _____ (check & initial) I understand and agree with the fees for massage therapy, to be paid at the time of service, and understand that appointments cancelled **within 24 hours prior** and **missed appointments** will result in a **$30.00 charge** to be paid before further treatment is booked. Substitutions of family/friends for appointments that you are not able to attend are accepted with no charge.

- I understand the expected benefits to the treatment (decreased muscle tension, decreased pain, increased range of motion), possible risks and side effects (including but not limited to: aggravation of pre-existing symptoms, temporary soreness, bruising, redness/swelling, headache or light-headed, minor skin irritation from lotions), and possible consequences of not receiving this treatment (condition may remain the same or worsen).

- I understand that I may stop, alter or withdraw my consent to treatment at any time before, during or after the massage.

- If I experience an uncomfortable level of pain during the treatment I will immediately inform the therapist so that the pressure or technique may be adjusted to my level of comfort.

- I am aware that I can remove only the clothing that is comfortable for me for a treatment.

- All information contained on my Health History, as well as anything shared verbally within any treatment will remain confidential between my RMT and myself unless I give written consent to share this with other professionals, or if the law requires.

_____ _____

Signature of Patient Date