Perfect Balance
Wellness Centre

CONFIDENTIAL HEALTH HISTORY

A complete and accurate health history is necessary to ensure safe and appropriate massage therapy treatment.

NAME: First_____ Last_____

Address: _____ City _____ Postal Code _____

PHONE: Home _____ Cell _____

Email: _____

Date of Birth: _____ Occupation: _____

Primary Complaint: _____

Have you previously received massage therapy? ❑ Yes ❑ No

Are you currently receiving treatment from other health care professionals (Naturopath, Physiotherapist, Surgeon, Oncologist, etc.)? ❑ Yes ❑No (If yes, please provide details)

_____

_____

Primary Care Physician (Name & Address): _____

General Health: ❑ Poor ❑ Fair ❑ Good ❑ Excellent

How did you choose Crystal Mitchell RMT?

Please indicate conditions you are experiencing or have experienced in the past.

Location of any muscle or joint discomfort:
❑ Neck
❑ Shoulders
❑ Upper back
❑ Mid back
❑ Lower back
❑ Arm
❑ Elbow
❑ Wrist
❑ Hand
❑ Hip
❑ Leg
❑ Knee
❑ Ankle
❑ Foot

Head/Neck
❑ History of headaches
❑ History of migraines
❑ Vision problems
❑ Vision loss
❑ Ear problems
❑ Hearing loss

Cardiovascular
❑ High blood pressure
❑ Low blood pressure
❑ Chronic congestive heart failure
❑ Heart disease
❑ Heart attack
❑ Phlebitis/varicose veins
❑ Stroke (CVA)
❑ Pacemaker or similar device
❑ Known family history of any of the above

Women
❑ Pregnant, Due: _____
❑ Gynaecological conditions: _____

Infections
❑ Skin conditions
❑ Respiratory conditions (TB)
❑ Hepatitis
❑ HIV/AIDS
❑ Herpes

Respiratory
❑ Chronic cough
❑ Bronchitis
❑ Shortness of breath
❑ Asthma
❑ Emphysema
❑ Known family history of any of the above

Other Conditions
❑ Loss of sensation (where?) _____
❑ Diabetes
❑ Allergies or Hypersensitivities _____
_____
_____
❑ Skin conditions
❑ Epilepsy
❑ Cancer (where) _____
_____
❑ Arthritis
❑ Known family history of arthritis

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Do you have any other diagnosed diseases or medical conditions (for example: digestive conditions, haemophilia, osteoporosis, etc.)? ❑ Yes ❑ No If yes, please provide details:

_____

_____

Do you have any internal pins, wires, artificial joints or special equipment? ❑ Yes ❑ No
If yes, please provide details: _____
Please list all current medications and the conditions they treat: _____

_____

_____

Please list the date and nature of all accidents, injuries, and surgeries: _____

_____

_____

Acknowledgements and Consent

By signing below, I acknowledge and/or agree that:
(please initial each box)

☐ The information I have provided is accurate and complete to the best of my ability.

☐ All information is confidential, and is collected, stored, and used in accordance with the Personal Health Information Protection Act, 2004 (PHIPA), and can only be disclosed as required or allowed by law.

☐ Crystal Mitchell RMT and/or Perfect Balance Wellness Centre may use my phone number and/or email address to send updates about changes to services, special events, or promotions, in accordance with Canada's Anti-Spam Legislation (CASL). I can withdraw this consent at any time by contacting the clinic.

☐ The gluteal area (buttocks) is considered a "sensitive area", and as such, the College of Massage Therapists (CMTO) requires specific, signed consent to treat it. The risks, benefits, possible complications and any contraindications have been explained to me. If it is deemed clinically appropriate, I consent to treatment of this area. I understand that I may withdraw this consent at any time.

☐ I am responsible for the payment of all fees for any treatments, services, reports, etc. incurred in the course of treatment. For fees that are billed directly to a third party (WSIB, Insurance, etc.), I understand that if at any time the third party insurer denies payment, I am responsible for any outstanding fees to be paid to Crystal Mitchell RMT. Any payment made by cheque that is returned due to insufficient funds will be subject to a $25 NSF fee.

☐ I will be charged in full for appointments missed, cancelled or rescheduled without advance notice of at least 24 hours.

Signature _____ Date _____