

# 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 Ryan Kimmich 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: \_\_\_\_\_

\_\_\_\_\_

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## 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.
- Ryan Kimmich 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 Ryan Kimmich 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 \_\_\_\_\_