CLIENT HEALTH HISTORY

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In accordance with the *Privacy Act*, the *Personal Information Protection and Electronic Documents Act*, the *Health Professions Act* and the *Bylaws of the College of Massage Therapists of B.C.,* it is my obligation to obtain your informed consent regarding the collection, use and disclosure of personal information prior to commencing your treatment.

I, ____ , understand that to provide me with a safe and effective treatment, the collection of personal health history information is required. This information is confidential and will not be released to anyone without my prior consent or as required by law. Should my health history change in the future and in order to maintain an accurate health history, I will notify my RMT at the next scheduled appointment.

I understand that I may modify the treatment plan at any time and can also alter, refuse or rescind my consent for treatment at any time. I also have the right to stop the treatment at any time.

I understand that I may be charged for a full treatment session if I do not call to cancel without a 24-hour notice. I also understand that if I show up late for my scheduled appointment, I may not receive treatment for my full scheduled time and I will pay for the appointment booked.

Signature:_______________________________________ Date: ____

Name: ____________________	General Health: ____________________
Address: ____________________	Occupation: ____________________
____________________	Chief complaint: ____________________
____________________	____________________
E-mail: ____________________	____________________
Home #: ____________________	____________________
Work #: ____________________	Have you had massage before? ☐ yes ☐ no Comments about your experience?
Alt #: ____________________	
Birth Date: ____________________	Who referred you to us/how did you find us?
Physician's Name & Address: ____________________	____________________
____________________	____________________
____________________	

Current Medication

Drug Name	Used For
____________________	____________________
____________________	____________________

Special Considerations Please indicate if you have any of the following: pacemaker, artificial joint(s) or limb(s), medication patch, artificial valves, rods, pins, wires, chemo/drug port, crutch, cane, wheelchair, other:

______________________________ ______________________________ ______________________________

______________________________ ______________________________ ______________________________

PLEASE CHECK ALL THAT APPLY

Respiratory
- ☐ Bronchitis / chronic cough
- ☐ Asthma
- ☐ Emphysema
- ☐ Shortness of Breath
- ☐ Other: ________________________

Cardiovascular
- ☐ High Blood Pressure
- ☐ Low Blood Pressure
- ☐ Angina
- ☐ Heart Attack
- ☐ Congestive Heart Failure
- ☐ Phlebitis / Deep Vein Thrombosis
- ☐ Poor Circulation
- ☐ Other: ________________________

Central Nervous System
- ☐ Epilepsy
- ☐ TIA / Stroke
- ☐ Multiple Sclerosis
- ☐ Parkinsonism
- ☐ Other: ________________________

Infectious Conditions
- ☐ Hepatitis Type: _____
- ☐ HIV / AIDS
- ☐ Tuberculosis
- ☐ Other: ________________________

Skin
- ☐ Infectious condition
- ☐ Warts
- ☐ Herpes
- ☐ Eczema
- ☐ Psoriasis
- ☐ Other: ________________________

☐ **Altered sensations**
Where?

How is your sleep? (quality/duration)

Allergy
- ☐ Hot/Cold
- ☐ Nuts
- ☐ Herbs
- ☐ Seasonal
- ☐ Oils, Creams, Lotions
- ☐ Aromas
- ☐ Latex
- ☐ Drugs ________________________
- ☐ History of anaphylaxis
- ☐ Other: ________________________

Musculoskeletal
(C=current ; P = Previous)
- ☐ C ☐ P Jaw Problem
- ☐ C ☐ P Neck Problem
- ☐ C ☐ P Shoulder Problem
- ☐ C ☐ P Arm Problem
- ☐ C ☐ P Wrist Problem
- ☐ C ☐ P Hand Problem
- ☐ C ☐ P Mid Back Problem
- ☐ C ☐ P Low Back Problem
- ☐ C ☐ P Hip Problem
- ☐ C ☐ P Knee Problem
- ☐ C ☐ P Ankle Problem
- ☐ C ☐ P Foot Problem
- ☐ C ☐ P Other ________________

☐ **Arthritis**
Type Where?

☐ **Headaches**
Type:
Where?

Digestion / Urination
- ☐ Constipation
- ☐ Irritable Bowel Syndrome
- ☐ Crohn's Disease
- ☐ Kidney Disease
- ☐ Recurrent Infection
- ☐ Prostate Problem
- ☐ Other ______________________

☐ **Diabetes**
Type:
Year Diagnosed: ______________
Complications:

☐ **Cancer** (C=current ; P = Previous)
Type:
Year Diagnosed: ______________
- ☐ C ☐ P Chemotherapy
- ☐ C ☐ P Radiation

Complications:

Women
- ☐ Pregnant Due: ______________
- ☐ Menstrual Issues
- ☐ Menopause Issues
- ☐ Breast pain
- ☐ Breastfeeding
- ☐ Endometriosis
- ☐ Other: ______________________

☐ **Vision Impairment**
☐ **Hearing Impairment**

Other Health Care You Receive
(C=current ; P = Previous)
- ☐ C ☐ P Naturopathic
- ☐ C ☐ P Chiropractic
- ☐ C ☐ P Physiotherapy
- ☐ C ☐ P Medical Specialist
- ☐ C ☐ P Other

☐ **Exercise**
Type Frequency

Injuries and Surgeries (please indicate if complications have occurred)

1. Type / Nature: ____ Date: ______________

2. Type / Nature: ____ Date: ______________

3. Type / Nature: ____ Date: __________

Other Conditions / Information ____

____

I attest that the health history information I have provided is accurate to the best of my knowledge.
Signature: ______________________________ Date:________________________________