RYAN M. HAYES
Registered Massage Therapist

Health History Form

The information requested below is important in providing a safe treatment for you. Please note that all information provided below will be kept confidential except as required or allowed by law. Your written permission will be required to release any information.

Name:________________________________ Tel. Home:________________________

Address:______________________________ Tel. Bus:__________________________

City:____________________ Province:______________ Date of Birth:______________________

Postal Code:__________ Email:____________________ Occupation:________________________

Emergency Contact:__________________________ Phone #:__________________________

Did a primary care physician refer you for massage therapy? ❑Yes ❑No ❑Other Referral:__________________
Primary Health Care Physician:________________________
Address:______________________________ Tel. No:__________________________

Would you be interested in? ❑Swedish Intuitive
❑General Intuitive

What is your general health status?________
____

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

Musculoskeletal
(Specify its nature: Pain, Stiffness, Numbness, Spasm)
- ❑ neck ________________
- ❑ shoulder ________________
- ❑ upper back ________________
- ❑ mid back ________________
- ❑ low back ________________
- ❑ arms ________________
- ❑ chest ________________
- ❑ legs ________________
- ❑ other ________________
- ❑ joints (list) ________________

Headache History
- ❑ tension
- ❑ migraines
- ❑ tooth/jaw/ear pain
- ❑ head trauma (date:____________)
- ❑ history of headaches
  type:____________________
- ❑ other: ____________________

- ❑ smoker

Gastroinstestinal
- ❑ irritable bowel syndrome
- ❑ colitis
- ❑ gastroenteritis
- ❑ Crohn's disease
- ❑ constipation

Skin
- ❑ skin condition
  specify____________________
- ❑ bruise easily
- ❑ herpes
- ❑ varicose veins
- ❑ athletes foot
- ❑ loss of sensation

Respiratory:
- ❑ chronic cough
- ❑ shortness of breath
- ❑ bronchitis
- ❑ asthma
- ❑ emphysema
- ❑ pneumonia
- ❑ sinus problems
- ❑ family history of any of above

Cardiovascular
- ❑ high blood pressure
- ❑ low blood pressure
- ❑ heart attack (date:____________)
- ❑ phlebitis / DVT
- ❑ stroke / CVA (date:____________)
- ❑ pulmonary emboli
- ❑ pacemaker
- ❑ heart disease
- ❑ angina
- ❑ chronic congestive heart failure
- ❑ family history of any of above

Infectious Disease
- ❑ hepatitis
- ❑ infections skin conditions
- ❑ tuberculosis
- ❑ HIV
- ❑ other:____________________

Other Conditions
- ❑ neurological conditions__________
- ❑ epilepsy
- ❑ diabetes/onset:______________
- ❑ allergies:____________________
  (❑ anaphylaxis; ❑ skin irritations)
- ❑ family history of allergies
- ❑ family history of hypersensitivities
- ❑ cancer____________________
- ❑ arthritis____________________
  type OA/RA/other:____________
  where:____________________
- ❑ family history of arthritis
- ❑ vision loss
- ❑ hearing loss
- ❑ insomnia
- ❑ haemophilia
- ❑ kidney/bladder problems
  (❑ dialysis)
- ❑ overactive bladder
- ❑ osteopenia
- ❑ osteoporosis
- ❑ positional vertigo
- ❑ mental illness:______________
- ❑ other:____________________

Accident/Injury

❑ Car accident ❑ Work related ❑ Other

Date:________________________________

Symptoms:____

Physical Limitations:_________________________________

Surgery

Type:____

Date: _______________________________

Current symptoms:__________________________________

❑ **Pins / Wires / Prosthetics:**__________________________

Women

- ❑ pregnant (due date:___________________)
- ❑ gynecological conditions:__________________________
- ❑ breast pain
  - ❍ cyst
  - ❍ breast lift (date:___________________)
  - ❍ breast augmentation (date:__________________)
  - ❍ breast reduction (date:_____________________)

Current Medication and Conditions Treated

❑ **Present involvement in other Health Care: Yes / No**

If Yes, specify:____________________________________

❑ **Medical Alert Bracelet** (specify condition / allergy)

I have read the above information and have stated all my previous and current medical conditions. I take it upon myself to update the massage therapist regarding any changes in my condition. I understand that all massage treatments will be discussed and planned with the massage therapist, and will require my informed consent. I understand the 24 hour cancellation policy and agree to pay the missed appointment fee if I cancel within the 24 hour period preceding my appointment time. I understand the lateness policy that I am responsible to pay for the time I reserved with the therapist, regardless of the time I arrive and I am ready for my appointment.

Signature of Client:__________________________________ Date:____

UPDATED

Client Signature:____________________________________ Date:____

Client Signature:____________________________________ Date:____

Client Signature:____________________________________ Date:____

Client Signature:____________________________________ Date:____