Argyle Park Natural Health Centre Massage Therapy
PATIENT HISTORY

For safety and accuracy please fill out completely and to the best of your knowledge.

Last name_____ First Name_____
Address_____
Postal Code_____ City_____Prov_____
Occupation_____
Phone (home)_____Work_____Cell_____
Birthday_____ Health Card #_____
Email_____
-Do you want to be contacted by email for massage promotions? Yes No

Physician_____ Phone_____
Address _____

Medical History

Have your received treatment from any of the following for your current condition?

☐	Physician	Reason for treatment?_____
☐	Chiropractor	_____
☐	Physiotherapist	_____
☐	Massage Therapist	_____
☐	Acupuncturist	_____
☐	Other	_____

Have you been diagnosed or treated by a physician for any of the following?

☐ Anemia	☐ Constipation	☐ Hepatitis/liver disease
☐ Anxiety	☐ Depression	☐ Kidney Disorders
☐ Allergies	☐ Diabetes	☐ Lung Disorders
☐ Asthma	☐ Difficulty Swallowing	☐ Neurological Condition
☐ Backaches	☐ Digestive Disorders	☐ Numbness/Tingling
☐ Bleeding Disorders	☐ Dizziness	☐ Osteoporosis
☐ Blood Pressure	☐ Epilepsy/Seizures	☐ Sleep Disturbance
☐ Cancer	☐ Fracture/ broken bones	☐ Skin conditions
☐ Chronic Fatigue	☐ Heart conditions	☐ Thyroid Disease
☐ Cholesterol	☐ TMJ	☐ Varicose Veins
☐ Circulatory Problems	☐ Headaches	☐ Whiplash
☐ Concussion/Head Injury	☐ HIV	☐ Arthritis

Explain_____
_____
_____

Are you taking any prescription or non-prescription medications?

Name	Reason	Duration
_____	_____	
_____	_____	
_____	_____	

Family Medical History

Does your immediate family have any of the following conditions?

☐ Back Pain	☐ Blood Pressure Problems	☐ Cancer
☐ Arm/shoulder pain	☐ Heart disorders	☐ Headaches
☐ Neurological conditions	☐ Arthritis	☐ Diabetes
☐ Respiratory Conditions	☐ Digestive Disorders	☐ Other

Explain_____

_____

Where is your current pain?

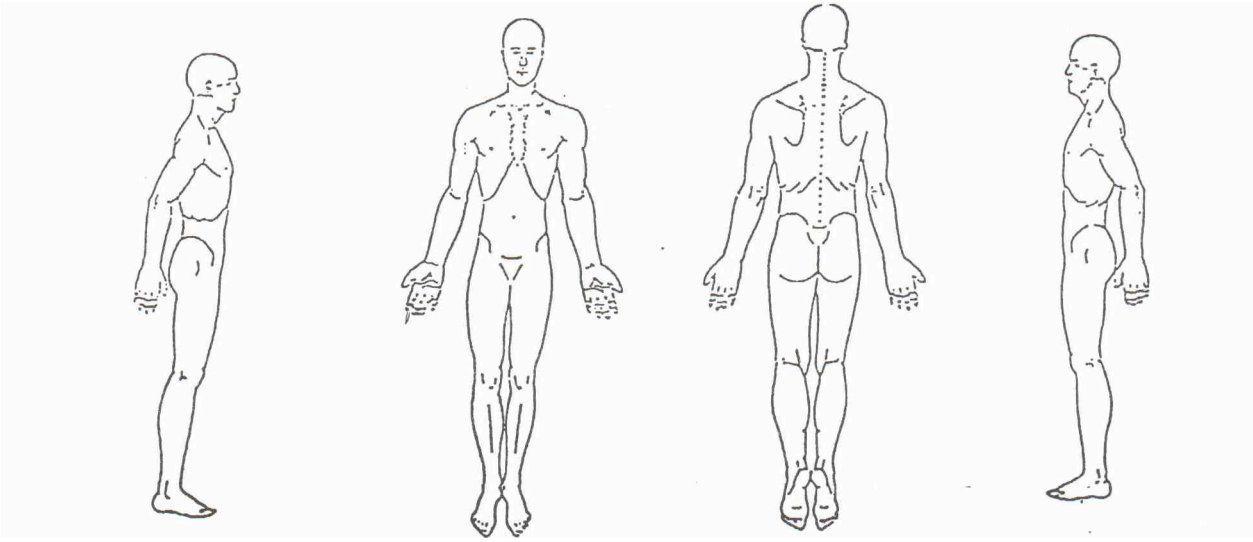
Please describe your present complaint _____

_____

List previous injuries, accidents or surgeries and their dates or year:

_____

_____



Social History

Smoking per day (packs) ☐ none	☐ half	☐ one	☐ two		
Glasses of water a day	☐ none	☐ 1-2	☐ 3-4	☐ 5 +	
Alcohol beverages a week	☐ none	☐ 1-2	☐ 3-4	☐ 5 +	
Exercise hours per week ☐ none	☐1	☐2-3	☐ 4+		

Work Stress	☐ low	☐ moderate	☐ high
Home Stress	☐ low	☐ moderate	☐ high

I understand that confidentiality will be respected but information may be shared with my physician, SGI or WCB representatives, or other health care providers if necessary.

The information provided and documented on this form is true and accurate to the best of my knowledge.

_____ _____

Signature of patient Date

INFORMED CONSENT TO MASSAGE THERAPY TREATMENT

I understand that the Massage Therapist is providing massage therapy services within their scope of practice as defined by their current associations.

I hereby consent to my therapist to treat me with massage therapy for the above noted purposes including such assessments, examinations, which may be recommended, by my Therapist. I understand that his is a professional treatment and my therapist has a right to stop treating me at any time.

I acknowledge that the Therapist is not a physician and does not diagnose illness or disease or any other physical or mental disorder. I clearly understand that massage therapy is not a substitute for a medical examination. It is recommended that I attend my personal physician for any aliments that I may be experiencing. I acknowledge that with any treatment there can be risks and those risks have been explained to me and I assume those risks.

I acknowledge and understand that the Therapist must be fully aware of my existing medical conditions. I have completed my medical history form, and disclosed to the Therapist all of those medical conditions affecting me. It is my responsibility to keep the Massage Therapist updated on my medical history. The information I have provided is true and complete to the best of my knowledge.

I authorize my Therapist to release or obtain information pertaining to my condition(s) and/or treatment to/from my other caregivers or third party payers.

I have read the above noted consent and I have had the opportunity to question the contents and my therapy. By signing this form, I consent to treatment and intend this consent to cover the treatment discussed with me and such additional treatment as proposed by my Therapist from time to time, to deal with my physical condition and for which I have sought treatment. I understand that at any time I may withdraw my consent and treatment will be stopped.

_____ _____

PATIENT NAME SIGNATURE OF PATIENT OR GUARDIAN

_____

DATE SIGNED