Navdeep Toor, RMT | Phone: 647.740.8417
9983 Keele Street (Suite 104), Maple, Ontario, L6A 3Y5
WWW.BACKTOBASICS.CARE

Health History Form

The information request below will assist us in treating you safely. Feel free to ask any questions about the information being requested. Please note that all information provided below will be kept confidentially unless allowed or required by law. Your written permission will be required to release any information.

Name: _____ Phone # _____
Address:_____
Email Address:_____
Occupation:_____ Date of Birth: _____

Have you received massage therapy before? □ Yes □ No
Did a health care practitioner refer you for massage therapy? □ Yes □ No
If yes, please provide their name and address. _____

Please indicate conditions you are experiencing or have experienced:

Cardiovascular
□ high blood pressure
□ low blood pressure
□ chronic congestive heart failure
□ heart attack
□ phlebitis / varicose veins
□ stroke/CVA
□ pacemaker or similar device
□ heart disease

Is there a family history of any of the above? □ Yes □ No

Respiratory
□ chronic cough
□ shortness of breath
□ bronchitis
□ asthma
□ emphysema

Is there a family history of any of the above? □ Yes □ No

Infections
□ hepatitis
□ skin conditions
□ TB
□ HIV
□ herpes

Other Conditions
□ loss of sensation, where?
_____
□ diabetes, onset: _____
□ allergies/hypersensitivity to what? _____
type of reaction: _____
□ epilepsy
□ cancer, where?
_____
□ skin conditions, what?
_____
□ arthritis
Is there a family history of arthritis?
□ Yes □ No

Head/Neck
□ history of headaches
□ history of migraines
□ vision problems
□ vision loss
□ ear problems
□ hearing loss

Women
□ pregnant, due:_____
□ gynaecological conditions, what?_____

Overall, how is your general health?
_____

Primary Care Physician:
_____
Address:
_____

_____

Current Medications/Conditions Used For: _____

Are you currently receiving treatment from another health care professional? □ Yes □ No _____

Surgery – date _____ nature: _____
Injury – date _____ nature: _____

Do you have any other medical conditions? (e.g. digestive conditions, haemophilia, osteoporosis, mental illness) □ Yes □ No
what? _____
Do you have any internal pins, wires, artificial joints or special equipment ? □ Yes □ No
If yes, for what? _____ where? _____

What is the reason you are seeking massage therapy? Please include the location of any tissue or joint discomfort.
_____
_____

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CURRENT COMPLAINT

Sharp__ Dull__ Throbbing__ Aching__ Burning_____ Stabbing_____

Weakness_____ Numbness_____ Tingling_____ Other_____

Location: _____

When did it begin: _____ Have you had this problem before: Y N When: _____

How did this happen? _____

What makes it worse? _____ What makes it better? _____

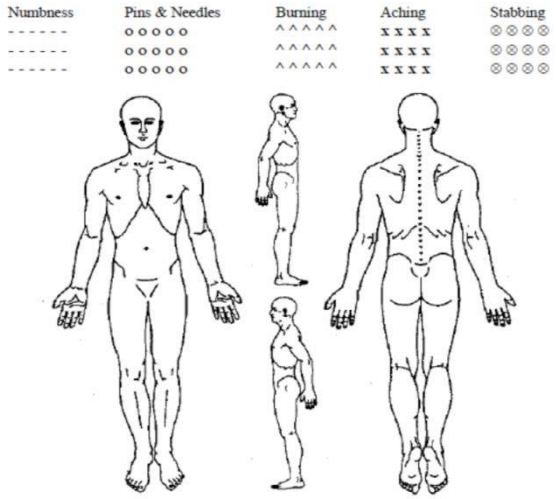
Does the pain radiate? _____ If yes, where? _____

Is the pain (circle): Constant / Intermittent / Varies / No-Pattern

On a scale from 1 to 10 (10 being the worst pain you've ever experienced), how would you rate your pain?_____

Is it worse (circle): In the morning / Mid-Afternoon / Evening At night (wakes me up)

Please indicate on these figures where you are experiencing your current complaints. Use the legend as a guide



Date of initial Health History:_____
Update 1 _____
Update 2 _____
Update 3 _____
Update 4 _____

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INFORMED CONSENT TO TREATMENT

I understand that the massage therapist is providing massage therapy services within their scope of practice as defined by the College of Massage Therapist of Ontario. I understand that my therapist follows provident health information privacy act laws, and that I can request to see the privacy policy at any time.

I hereby consent for my therapist to treat me with massage therapy for the above noted purposes including such assessments, examinations, and techniques, which may be recommended, by my therapist.

I acknowledge that the therapist is not a physician and does not diagnosis illness, 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 I attend my personal physician for any ailments that I may be experiencing. I acknowledge that no assurance or guarantee has been provided to me as to the results of the treatment.

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 as provided by my therapist 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 have read the above noted consent and I have had the opportunity to question the contents of my therapy. By signing this form, I confirm my consent to treatment and intend this consent to cover the treatment discussed with me and such additional treatment as proposed by my therapist. I understand that at any time, I may withdraw my consent and treatment will be stopped.

Patient Name (PRINT) _____ Patient Signature_____

Date: _____

Cancellation and Late Arrival Policy

Please be informed that at least 24 hours notice is required to change or cancel an appointment. If sufficient notice is not given, you will be charged the full fee for the missed appointment.*

Should you arrive late, you will receive the remaining time in the appointment but you will be billed for the full amount.

Thank you for respecting our time and the time of your fellow patients.

Agreement by patient: by continuing with my treatment, I hereby declare that I agree to the above cancellation policy.

*some situations may be excluded, at your therapist discretion.