Georgia Poulis, RMT
HEALTH HISTORY FORM

FYI: AN ACCURATE HEALTH HISTORY FORM ENSURES THAT IS SAFE FOR YOU TO RECEIVE A MASSAGE TREATMENT AND HELPS THE THERAPIST TO DETERMINE A PROPER TREATMENT PLAN. IF YOUR HEALTH STATUS CHANGES IN THE FUTURE PLEASE LET US KNOW. ALL INFORMATION ON THIS FORM IS CONFIDENTIAL. YOUR WRITTEN CONSENT IS LEGALLY REQUIRED BEFORE IT CAN BE RELEASED.

PERSONAL INFORMATION (PLEASE PRINT)

Name:_____ Date:_____

Address:_____ Postal Code:_____

Home Phone:_____ Work Phone:_____ Cell Phone:_____

Occupation:_____ Email:_____ May I contact you via Email? Yes____ No____

Date of Birth_____ Height:_____ Weight:_____

Primary Care Physician: _____ Phone: _____

Address: _____ May I contact? Yes _____ No _____

Emergency Contact Name: _____ Phone: _____

How did you hear of us?_____ Referred by:_____

Have you received massage therapy before? Yes _____ No _____ for relaxation or another reason?_____

Did a health care provider refer you for massage therapy? Yes _____ No _____

If yes please provide their name and address: _____

What is your primary complaint? _____

When did your symptoms begin? _____

Current Medications: _____

Condition it treats: _____

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

If yes, for what? _____

Previous major illnesses, operations: _____

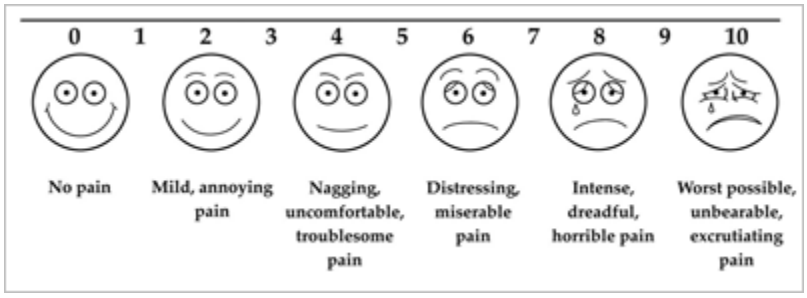
Injuries and/or accidents (please give dates): _____

Do you have any other medical conditions (eg. Haemophilia, osteoporosis, mental illness) Yes _____ No _____

If yes, what? _____

Do you have any internal pins, wires, artificial joints or special equipment? _____

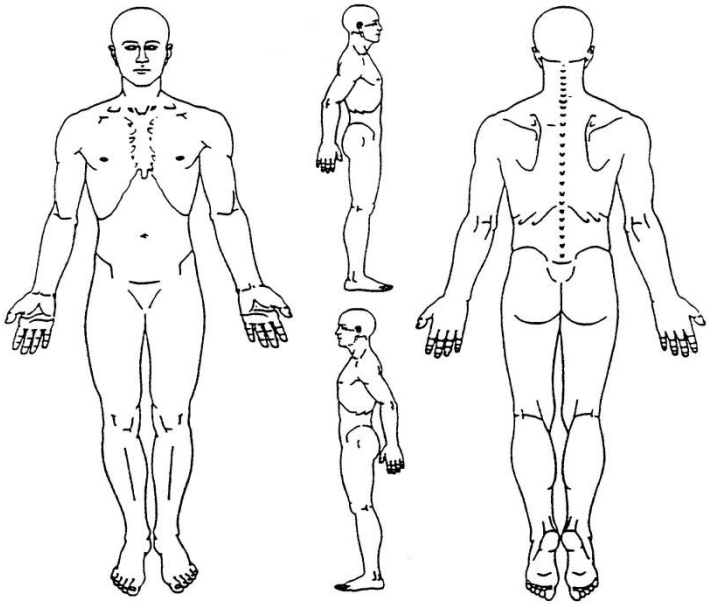
Please rate your pain level



Is this condition interfering with (circle all that applies):

WORK SLEEP DAILY ROUTINE ACTIVITIES

PLEASE INDICATE ON THE DIAGRAM BELOW THE LOCATION(S) OF YOUR SYMPTOMS



Which best describes your pain?

___ sharp ___ dull

___ deep ___ throbbing

___ constant ___ intermittent

___ shooting ___ poorly localized

___ superficial ___ well localized

___ burning ___ brief, transient

___ aching

What increases your pain? _____

_____

What relieves your pain? _____

_____

Have you experienced any of the following conditions? Is so, please indicate which ones

Cardiovascular

- o High blood pressure
- o Low blood pressure
- o Chronic congestive heart failure
- o Heart attack
- o Phlebitis/varicose veins
- o Stroke/CVA
- o Pacemaker or similar device
- o Heart disease

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

Respiratory

- o Chronic cough
- o Shortness of breath
- o Bronchitis
- o Asthma
- o Emphysema
- o Smoker?

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

Head and Neck

- o History of headaches
- o History of migraines
- o Vision problems
- o Vision loss
- o Ear problems
- o Hearing problems

Soft Tissue / Joint Pain

- o Neck
- o Upper back/shoulders
- o Arms/hands
- o Mid Back
- o Low back
- o Hips
- o Legs
- o Knees
- o Feet
- o Other _____

Infections

- o Hepatitis
- o Skin conditions/rash
- o TB
- o HIV
- o Herpes

Women

- o Pregnant. Due: _____
- o Gynaecological issues
  What? _____

Gastrointestinal

- o Diarrhea
- o Indigestion/heartburn
- o Constipation
- o Other: _____

Other

- o Loss of sensation.
  Where? _____
- o Diabetes. Onset _____
- o Allergies. To what?_____
- o Epilepsy
- o Cancer. Where?_____
- o Fibromyalgia
- o Swelling in the ankles
- o Bruise easily
- o Arthritis

Is there a family history of arthritis?
___ Yes ___ No

Lifestyle Questions

Regular eating habits ___ Yes ___ No
Do you take vitamins? ___ Yes ___ No
type_____
frequency_____
Regular Exercise ___ Yes ___ No
type_____
frequency_____
Energy level
high ____ average ____ low _____
Do you suffer from stress?
___ Yes ___ No
Do you use a computer?
___ Yes ___ No
How many hours per day _____

WHAT ARE YOUR GOALS FOR MASSAGE THERAPY?_____

_____

Georgia Poulis, RMT
MASSAGE THERAPY HEALTH AND CONSENT FORM
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PRIVACY & HEALTH CONSENT

NOTE TO CLIENT: We want your informed consent. This means that we want you to understand the services we provide to you, the cost involved, and what we do with personal information we obtain about you. Please feel free to discuss any question or concerns about your privacy or health, with your treating practitioner. The information you provide us with will be kept confidential unless you submit a written request for us to release your information or if required by law.

INFORMED CONSENT TO MASSAGE THERAPY TREATMENT

I understand that Georgia Poulis, RMT is providing massage therapy services within her scope of practice as defined by the College of Massage Therapists of Ontario (CMTO).

I hereby consent for Georgia Poulis, RMT to treat me with massage therapy for the above noted purposes including such as assessments, examinations and techniques.

I acknowledge that Georgia 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 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 that those risks have been explained to me and I assume those risks.

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

I authorize Georgia Poulis, RMT to release or obtain information pertaining to my condition(s) and/or treatment to/from my other caregivers or third party payers. I agree that my health and/or accident insurance are in agreement between the carrier and myself and I am fully responsible for my appointment fees. I understand that all accounts are due and payable at time of service. I understand that I will be given receipts.

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 confirm my consent to treatment and intend this content to cover the treatment discussed with me and such additional treatments as proposed by Georgia Poulis, RMT. I understand that at any time I may withdraw my consent and treatment will be stopped.

24 HOUR CANCELLATION POLICY

I acknowledge that if I am late for my scheduled appointment, I lose privilege to a full treatment. Should the need to change or cancel my appointment, *24 hours' notice is required or full charges will apply*. I understand the need to notify my therapist as someone else in need could utilize my appointment time. Missed appointment fees will not be billed to my insurance company.

Printed Name: _____ Signature: _____

Therapist Name: _____ Signature: _____

Date:_____

Updates to health history
Update 1_____
Update 2_____
Update 3_____
Update 4_____