The Art of Massage-Essential Healing

HEALTH HISTORY FORM

Name: Date:

Address: Phone number:

Date of birth: E-mail:

Allergies:

Work/Hobbies:

Are you under medical care for any of the following: (circle)

Heart conditions	High/low blood pressure	Fainting/Dizziness
Varicose veins	Phlebitis/Circulatory problems	Headaches/Migraine
Neck injury	Diabetes	Jaw or Ear pain
Back injury	Rheumatoid Arthritis	Skin conditions
Cancer	Osteoarthritis	Fibromyalgia
Osteoporosis	Asthma	Depression
Crohn's/Colitis	Whiplash	
Nervous Disorder	Kidney Disease	Other:

Have you received care from any of the following: (circle)

Physiotherapist Chiropractor Massage Therapist Other:

1) Reason for treatment:

2) Please list your current medications and what they are for:

3) Please list major surgeries, illnesses or accidents:

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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 the Natural Health Practitioners of Canada.

I hereby consent for my therapist, **Jackie Hunter**, 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 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 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 and 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 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.

Signature of Patient/Guardian: _____

Date Signed: _____