FOREST HILL PHYSIOTHERAPY & HEALTH CENTRE
361 Eglinton Ave West • Toronto, ON • M5N 1A3 • Tel: 416.551.7111

Massage Therapy Intake and Health History

Date:

The information requested 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 confidential unless allowed or required by law. Your written permission will be required to release any information

Name:	Date of Birth:	
Address:		
City:	Province:	Postal Code:
Home Phone:	Work Phone:	Cell Phone:
Email:	Preferred Method of Contact:	
Occupation:		
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 phone number:		
Family physician name and phone number:		
Have you received treatment from another health care professional in the past year? [] Yes [] No		
If yes, please provide type of treatment (chiropractic, physiotherapy, etc.):		
Emergency Contact:	Phone:	
Do you have extended health care benefits? [] Yes [] No If yes, company name: Permission to verify information on issued receipt with insurer [] Yes [] No		
Primary Complaint:		
Injuries:	Date of occurrence:	
Were these injuries sustained as a result of a motor vehicle accident? [] Yes [] No		
Were these injuries sustained at work? [] Yes [] No		
Please list all surgeries and dates:		
Please list all current medications and conditions they are treating:		

FOREST HILL PHYSIOTHERAPY & HEALTH CENTRE
361 Eglinton Ave West • Toronto, ON • M5N 1A3 • Tel: 416.551.7111

Please indicate conditions you are experiencing or have experienced:

Cardiovascular:
- [ ] High Blood Pressure
- [ ] Low Blood Pressure
- [ ] Chronic Congestive Heart Failure
- [ ] Heart Attack
- [ ] Heart Disease
- [ ] Heart Palpations
- [ ] Heart Murmur
- [ ] Stroke / CVA
- [ ] Aneurism
- [ ] Angina
- [ ] Blood Clots
- [ ] Raynaud's Disease
- [ ] Phlebitis / Varicose Veins
- [ ] Poor Circulation
- [ ] Pacemaker or Similar Device

Respiratory:
- [ ] Chronic Cough
- [ ] Shortness of Breath
- [ ] Bronchitis
- [ ] Asthma
- [ ] Emphysema
- [ ] Pneumonia
- [ ] Tuberculosis
- [ ] Sinusitis
- [ ] Sinus Congestion

Do you smoke [ ] Yes [ ] No [ ]

Blood:
- [ ] Anaemia
- [ ] Haemophilia
- [ ] Leukemia
- [ ] Hepatitis A B C

Lifestyle:

Regular Exercise
[ ] Yes [ ] Mostly [ ] No

Drink Plenty of Water
[ ] Yes [ ] Mostly [ ] No

8 Hours of Sleep Nightly
[ ] Yes [ ] Mostly [ ] No

Good Eating Habits
[ ] Yes [ ] Mostly [ ] No

Gastrointestinal:
- [ ] Constipation
- [ ] Diarrhea
- [ ] Gas / Bloating
- [ ] Nausea / Vomiting
- [ ] Irritable Bowel Syndrome
- [ ] Crohn's / Colitis
- [ ] Hernia
- [ ] Ulcers
- [ ] Gall Bladder Problems
- [ ] Liver Problems
- [ ] Kidney Infections
- [ ] Bladder Infections
- [ ] Urination Problems
- [ ] Poor Appetite
- [ ] Excessive Thirst

Skin:
- [ ] Allergies:
- [ ] Hypersensitivity
- [ ] Bruises Easily
- [ ] Rashes
- [ ] Eczema
- [ ] Psoriasis
- [ ] Athletes Foot
- [ ] Herpes
- [ ] Warts
- [ ] Skin Conditions:

Women:
- [ ] Pregnant, Due:
- [ ] Infertility
- [ ] Menstrual Concerns / Pain
- [ ] Menopausal Concerns
- [ ] Endometriosis
- [ ] Fibroids
- [ ] Hysterectomy
- [ ] Vaginal Pain / Infection

General Health:
[ ] Good [ ] Fair [ ] Poor

Other (please list):_____
_____

Head / Neck:
- [ ] Headaches
- [ ] Migraines
- [ ] Whiplash
- [ ] Jaw Pain
- [ ] Ear Pain
- [ ] Hearing Problems
- [ ] Hearing Loss
- [ ] Vision Problems
- [ ] Vision Loss

Muscle / Joint:
- [ ] Muscle Strain
- [ ] Ligament Sprain
- [ ] Spasms / Cramps
- [ ] Tendinitis
- [ ] Bursitis
- [ ] Fibromyalgia
- [ ] Ankylosing Spondylitis
- [ ] Arthritis OA RA
- [ ] Osteoporosis
- [ ] Herniated Disc
- [ ] Degenerative Discs
- [ ] Joint or Bone Disease
- [ ] Scoliosis
- [ ] Dislocation
- [ ] Fracture

Other Conditions:
- [ ] Diabetes, onset:
- [ ] HIV / AIDS
- [ ] Cancer
  Type?
- [ ] Multiple Sclerosis
- [ ] Epilepsy
- [ ] Thyroid Disorders
- [ ] Lupus
- [ ] Loss of Sensation
  Where?
- [ ] Insomnia / Fatigue
- [ ] Fainting / Dizziness
- [ ] Anxiety / Nervousness
- [ ] Depression
- [ ] Alcohol / Drug Addiction

Is there a family history of any of the conditions listed above? _____

Do you have any internal pins, wires, artificial joints or special equipment? [ ] Yes [ ] No If yes, where? _____

FOREST HILL PHYSIOTHERAPY & HEALTH CENTRE
361 Eglinton Ave West • Toronto, ON • M5N 1A3 • Tel: 416.551.7111

Please ensure you read the following information in its entirety.

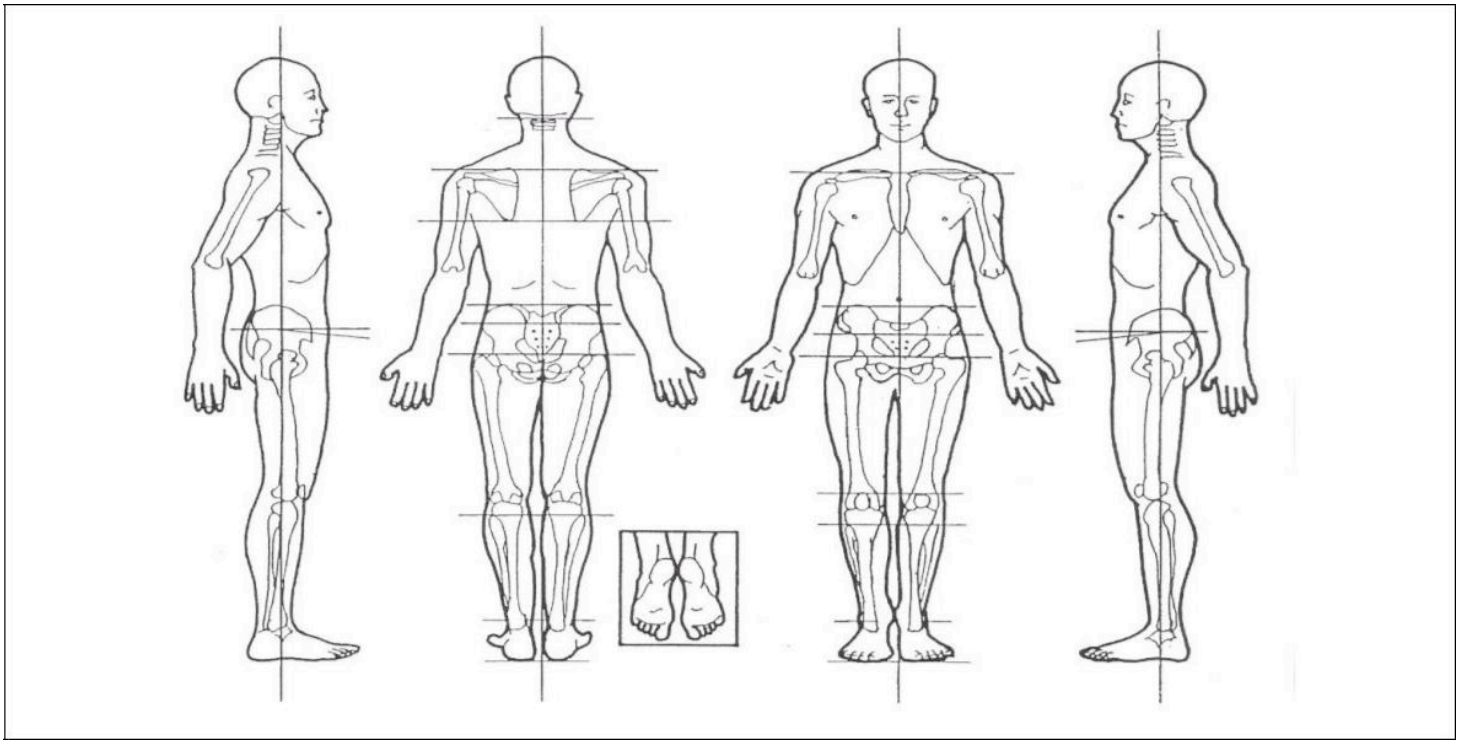
I have read the above information and have stated all my previous and current medical conditions. I will update the Registered Massage Therapist regarding any updates in my condition as soon as possible.

In order to provide treatment, this clinic must collect personal health information. I understand that all information that I provide will be kept confidential unless allowed or required by law. I understand that I will be asked for written authorization before this information can be released.

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 that I am responsible to pay for the time reserved with the Registered Massage Therapist; regardless of the time I arrive and am ready for my appointment. I understand that this time will include intake, assessment, treatment, self-care recommendations, charting and administration. I understand that payment in full is due on the day of treatment.

Signature: _____ Date: _____

Chart for Registered Massage Therapist's Use Only



FOREST HILL PHYSIOTHERAPY & HEALTH CENTRE
361 Eglinton Ave West • Toronto, ON • M5N 1A3 • Tel: 416.551.7111

Massage Therapy Assessment and Treatment Consent Form

Please read carefully and sign before receiving therapy. All information provided is confidential and will not be given out to anyone.

I understand that the massage I receive is provided for the purpose of relaxation and/or relief of muscular tension. If I experience any discomfort during the session, I will immediately inform the therapist so that the pressure and strokes may be adjusted. I further understand that massage should not be construed as a substitute for medical examination, diagnosis, or treatment. I understand that my RMT is not qualified to perform spinal or skeletal adjustments, diagnose, prescribe, or treat any physical or mental illness. However, my therapist will refer me to the required health professional if needed.

I understand that any illicit or sexually suggestive remarks or advances made by me will result in immediate termination of the session.

I also understand that the Licensed Registered Massage Therapist reserves the right to refuse or terminate massage session to anyone whom he/she considers to have a condition for which massage is contraindicated.

_____	_____	_____
Name of Client	Signature of Client	Date

The following page to be filled out with practitioner as needed.