healthworks
chiropractic & wellness centre

357 king St., midland ON L4R 3M7
t: (705) 526 6900 f: (705) 526 6460

Registered Massage Therapy

Date: _____

Please Read Carefully

An accurate health history is important to ensure that it is safe for you to receive massage treatment. If your health status changes in the future, please let Health Works Chiropractic & Wellness Centres' Massage Therapist know. Health history will be updated yearly. All information gathered for this treatment is confidential except as required or allowed by law; or except to facilitate assessment or treatment. You will be asked to provide written authorization for release of any information.

Name: _____

Address: _____

City: _____

Province: _____

Home Phone Number: (____) _____

Postal Code: _____

Cell Phone Number: (____) _____

Birth Date: _____/____/_____ Age: _____
MM / DD / YEAR

Cell Phone Provider: _____

Emergency Contact: _____

Occupation: _____

Emergency Phone No.: (_____)_____

Work Phone Number: (_____)_____

Email Address: _____

Referred by: _____

How would you like appointment reminders? ☐ Home Phone ☐ Texting ☐ Email

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Treatment Notes for: _____ Date: _____ DOB:_____

Health History **Please indicate any conditions you are experiencing or have experienced.**

Cardiovascular
□ high blood pressure
□ low blood pressure
□ congestive heart failure
□ pacemaker / device
□ heart disease / heart attack
□ stroke / CVA
□ other: _____

Respiratory
□ chronic cough
□ shortness of breath
□ bronchitis
□ emphysema
□ asthma
□ other: _____

Infections
□ hepatitis
□ skin infection: _____
□ TB
□ HIV
□ other: _____

Bone
□ osteoporosis
□ osteomalacia
□ arthritis/family history
□ other

Other Conditions
□ epilepsy
□ diabetes, onset: _____
□ loss of sensation, where?
_____
□ cold hands and / or feet
□ varicose veins
□ allergies: _____
□ cancer
□ other: _____
□ skin irritations or conditions:
_____

Women
□ pregnant
due: _____

Head / Neck
□ vision problems
□ hearing problems / loss
□ sinus problems
□ TMJ (jaw problems)
□ headaches / migraines
□ other:
_____

Soft Tissue / Joint Discomfort
(please state nature of concern)
□ neck: _____
□ shoulders: _____
□ upper back: _____
□ mid back: _____
□ low back: _____
□ arms:
_____
□ legs: _____
□ other:
_____

Did a health care practitioner refer you for massage therapy? ☐ Yes ☐ No
Do you have any internal pins, wires, artificial joints, or special equipment? ☐ Yes ☐ No
Have you had massage before? ☐ Yes ☐ No

Who may we thank for referring you to this office? _____

Other medical conditions:_____

Injury or Surgery:_____ Date:_____

_____ Date:_____

Medications: _____ Taken For: _____

Medications: _____ Taken For: _____

Doctors Names, addresses and phone numbers:
_____
_____
_____

Please fill in the form as completely as possible. Accuracy is very important.

Client Information Sheet for the Collection, Use and Disclosure of Personal Information

Privacy of your personal information is an important part of providing you with quality massage therapy. This information sheet will provide you with a general outline to ensure that:

- Only necessary information is collected about you.
- Your information is only shared with your consent.
- Storage, retention and destruction of your personal information complies with existing legislation and privacy protection protocols.
- Health Works Chiropractic & Wellness Centres' privacy protocols comply with privacy legislation, standards of our regulatory body, the College of Massage Therapists of Ontario and the Law.
- Your files and their contents are the property of Health Works Chiropractic & Wellness Centre and shall be used by our designated Registered Massage Therapy Practitioner.

I have reviewed the information above that explains how my personal information will be collected, used and disclosed. I understand and/or agree to the following:

- To provide me with massage therapy, some personal information about me (for example: name, address, telephone number and other healthcare providers) will be collected and agree to the terms and conditions as set out above.
- I have the right to discontinue my assessment or massage therapy treatment at any time.
- I have fully disclosed all medical conditions that I am aware of and understand that it will be my responsibility to inform at massage therapist of any changes in my health status.
- I intend this consent to apply to all of my present and future registered massage therapy care, provided through Health Works Chiropractic & Wellness Centre.

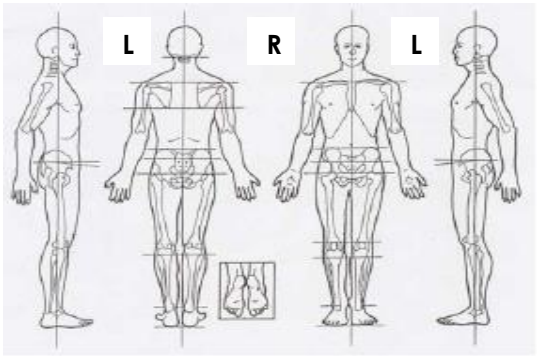
As stated in the "Consent to Treatment" Act, I have the right to consent to all or part of the session, or to withdraw consent at any time and have the right to know specifically what I am consenting to. I have the right to ask questions at any time and to communicate information (such as pain/discomfort levels) throughout the session to ensure my own safety and the effectiveness of the session.

I confirm that the information on this form is complete and true to the best of my knowledge and I understand that it is my responsibility to inform my therapist of any changes in my health status, as they occur.

_____	_____	_____
Date	**Print Name**	**Client Signature**
_____	_____	_____
Date	**Print Name**	**Witness' Signature**

Date: M M / D D / Y Y Y Y **Time:** _____a.m. p.m. **Duration:** _____minutes **Fee $**_____

Informed Consent Received: Treatment Assessment **Therapist:**_____

Techniques Used	Additional Treatment Notes	Areas Treated/Pressure
☐ Stroking ☐ Rocking ☐ Effleurage ☐ Petrissage ☐ Friction / Ice ☐ Vibration ☐ Tapotement ☐ Facial ☐ Trigger Point ☐ High grade joint mobilization ☐ Low grade joint mobilization ☐ Stretch ☐ Intra-Oral ☐ Breast Massage ☐ Other (list):	 Allergies: _____ Self Care: _____ Remedial Exercise(s):_____	Least **Most** 1 2 3 4 5 6 7 8 9 10 ☐ Back _____ ☐ Neck _____ ☐ Shoulders _____ ☐ Face _____ ☐ Arm _____ ☐ Leg _____ ☐ Gluteus _____ ☐ Abdominals _____ ☐ Chest _____ ☐ Breast _____ ☐ Other (list): _____

Comments: