HEALTH HISTORY FORM

Regent Massage

An accurate health history is important to ensure that it is safe for you to receive a massage treatment. All information gathered is confidential except as required or allowed by law. Written authorization will be required for release of any information. **This form must be updated annually.**

First Name: _____ **Last Name:** _____
(this is how your name will appear on your receipt)

Address: _____ **Tel. Home:** _____

City: _____ **Postal Code:** _____ **Tel. Cell:** _____

Date of Birth: (DD-MM-YY) DD / MM / YY **Gender: M / F**

Occupation: _____ **Email:** _____

Primary Health Care Physician: _____ Address: _____

General Health Status: _____ **1st Massage Treatment (ever): Yes/ No**

Primary Complaint: _____

How did you first hear about Regent Massage? _____

Health History: Please indicate ☑ conditions you are experiencing, present or past.

Soft Tissue/Joints
(Specify its nature: Pain, Stiffness, Numbness, Twitching, etc)

- ❑ neck _____ _____
- ❑ shoulder _____ _____
- ❑ upper back _____ _____
- ❑ mid back _____ _____
- ❑ low back _____ _____
- ❑ arms _____ _____
- ❑ chest _____ _____
- ❑ legs _____ _____
- ❑ knees _____ _____
- ❑ hips _____ _____
- ❑ other _____ _____

History of Headaches

- ❑ tension
- ❑ migraines
- ❑ jaw pain
- ❑ head trauma/date: _____

ACCIDENT/ INJURY

❑ Car Accident ❑ Sport Related ❑ Fall

Date: _____

Symptoms: _____

_____

_____

_____

Physical Limitations: _____

_____

Surgery (date, type)

1. _____
2. _____
3. _____

current symptoms _____

_____

_____

Respiratory

- ❑ chronic cough/bronchitis/emphysema
- ❑ shortness of breath
- ❑ asthma
- ❑ sinus problems

Cardiovascular

- ❑ high blood pressure
- ❑ low blood pressure
- ❑ heart attack/stroke (date:_____)
- ❑ heart disease
- ❑ chronic congestive heart failure

Infectious Disease

- ❑ hepatitis tuberculosis HIV
- ❑ infections skin conditions
- ❑ other: _____

Gastroinstestinal

- ❑ irritable bowel syndrome
- ❑ gastroenteritis/ colitis
- ❑ crohn's disease
- ❑ constipation

Skin

- ❑ bruise easily
- ❑ herpes
- ❑ varicose veins
- ❑ athletes foot
- ❑ **loss of sensation**_____
  _____

Exercise

- ❑ none
- ❑ moderate
- ❑ daily
- ❑ heavy

Work activity

- ❑ sitting
- ❑ standing
- ❑ light labor
- ❑ heavy labor

Other Conditions

- ❑ neurological conditions _____
- ❑ epilepsy
- ❑ diabetes/onset: _____
- ❑ allergies: _____
  (❑ anaphylaxis; ❑ skin irritations)
- ❑ fibromyalgia
- ❑ cancer _____
- ❑ arthritis _type: OA/RA/other:
  where _____
- ❑ hearing loss
- ❑ insomnia
- ❑ kidney/bladder problems
- ❑ overactive bladder
- ❑ osteoporosis
- ❑ positional vertigo
- ❑ mental illness: _____
- ❑ other: _____

Women

- ❑ pregnant / due date: DD /MM /YY
- ❑ gynecological conditions:
- ❑ breast pain/ cysts
  - ○ breast augmentation / reduction

for RMT use:

Health History UPDATED

Date: _____
Date: _____
Date: _____
Date: _____
Date: _____

Please initial: 48h cancellation policy _____

Current Medications (for what condition)

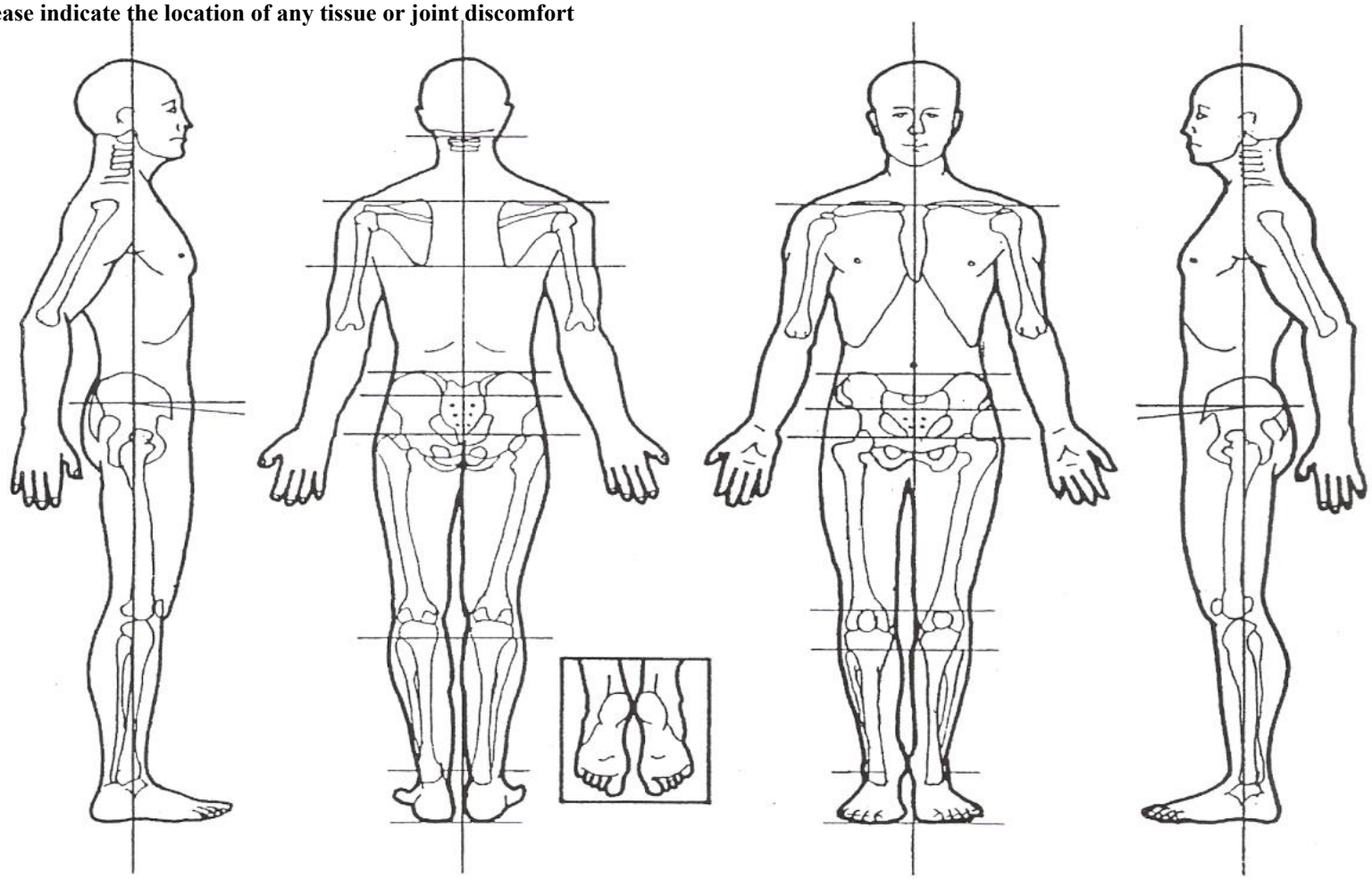
_____
_____
_____
_____
_____

Regent Massage

❑ **Present involvement in other Health Care: Yes/ No**
Specify: _____
_____

❑ **Pins / Wires/ Prosthetics:** _____
❑ **Medical Alert Bracelet** (specify condition / allergy)

Please indicate the location of any tissue or joint discomfort



Signature: _____ **Date:** _____

Consent for Assessment and Treatment of Sensitive Areas

I, _____ , have requested assessment and/or treatment by RMT Lara Navosha for treatment of the clinically relevant areas indicated below (please initial): ____ **Buttocks (gluteal muscles)** ____ **Chest Wall Muscles** ____ **Upper Inner Thigh(s)**

The RMT has explained the following to me and I fully understand the proposed assessment and/or treatment:

- The nature of the assessment, including the clinical reason(s) for assessment of the above area(s) and the draping methods to be used
- The expected benefits of the assessment
- The potential risks of the assessment
- The potential side effects of the assessment
- That consent is voluntary
- That I can withdraw or alter my consent at any time.

I voluntarily give my informed consent for the assessment and/or treatment as discussed and outlined above.

Client Signature: _____ Date: _____

Ongoing Treatment:
I am aware that the treatment of the above indicated area(s) is part of a treatment plan which has been discussed with me by my RMT. I confirm that, on the following date(s), the RMT has reviewed the treatment plan and I provide my informed consent.

Date:_____Signature:_____	Date:_____Signature:_____	Date:_____Signature:_____
Date:_____Signature:_____	Date:_____Signature:_____	Date:_____Signature:_____
Date:_____Signature:_____	Date:_____Signature:_____	Date:_____Signature:_____
Date:_____Signature:_____	Date:_____Signature:_____	Date:_____Signature:_____
Date:_____Signature: _____	Date:_____Signature: _____	Date:_____Signature: _____