Ceinwen Gobert RMT

HEALTH HISTORY

An accurate health history is important to ensure that it is safe for you to receive massage therapy. All information gathered for this treatment is confidential except as required or allowed by law. Written authorization will be required for release of any information.
24 hour cancellation notice is required otherwise a missed appointment fee will be charged.

Legal Name: ______________ Tel. Res.: ______________ Tel. Bus.: ______________

Address: ______________ City: ______________ Prov.: ________ Postal Code: ________

Date of Birth: ___/___/___ (mm dd yy) Occupation: ______________ Male: ☐ Female: ☐ 1st Massage Therapy Treatment? ☐ Yes ☐ No

Primary Health Care Physician: ______________ Address: ______________ Tel.: ______________

Primary Complaint: ______________ Source of Referral: ______________

General Health Status: ______________

Please indicate conditions you are or have experienced with a check mark: ☑

Soft Tissue/Joints
(specify its nature i.e. pain, stiffness, numbness etc.)

- ☐ neck ______________
- ☐ shoulder ______________
- ☐ upper back ______________
- ☐ mid back ______________
- ☐ low back ______________
- ☐ arms ______________
- ☐ legs ______________
- ☐ knees ______________
- ☐ hip ______________
- ☐ other: ______________

Headaches

- ☐ tension ☐ migraines
- ☐ tooth/jaw/ear pain
- ☐ head trauma - date: ______________
- ☐ other: ______________

GI tract conditions

- ☐ IBS ☐ Crohn's
- ☐ constipation
- ☐ other: ______________

Accident/Injury

- ☐ car accident work related? ☐ Yes ☐ No
- ☐ date: ______________
- ☐ symptoms: ______________

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- ☐ Physical limitations: ______________

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Surgery

- ☐ type: ______________
- ☐ date: ______________
- ☐ symptoms: ______________

____

Respiratory

- ☐ chronic cough
- ☐ shortness of breath
- ☐ bronchitis
- ☐ asthma - triggers: ______________

____

- ☐ emphysema
- ☐ pneumonia
- ☐ sinus problems

Cardiovascular

- ☐ high blood pressure
- ☐ low blood pressure
- ☐ heart attack - date: ______________
- ☐ phlebitis
- ☐ stroke/CVA - date: ______________
- ☐ pacemaker
- ☐ heart disease
- ☐ angina
- ☐ chronic congestive heart failure

Infectious Disease

- ☐ hepatitis
- ☐ infectious skin conditions
- ☐ tuberculosis
- ☐ HIV
- ☐ other: ______________

Women

- ☐ pregnant/due date: ______________
- ☐ previous labour complications:

____

Current medication & conditions

____

____

____

Skin

- ☐ skin condition
  specify: ______________
- ☐ bruise easily
- ☐ herpes
- ☐ varicose veins
- ☐ athletes foot
- ☐ loss of sensation

Other Conditions

- ☐ neurological condition: ______________
- ☐ epilepsy - triggers: ______________

____

- ☐ diabetes/onset: ______________
- ☐ allergies: ______________
  anaphylaxis? ☐ Yes ☐ No
  skin irritation? ☐ Yes ☐ No
- ☐ cancer
- ☐ arthritis - where? ______________
  type? ☐ RA ☐ OA other: ______________
  Family History? ☐ Yes ☐ No
- ☐ vision loss
- ☐ hearing loss
- ☐ insomnia
- ☐ hemophilia
- ☐ kidney/bladder problems
- ☐ other: ______________

Present involvement in other Health Care?

- ☐ Yes specify: ______________
- ☐ No ______________

Pins/Wires/Prosthetics

____

____

____

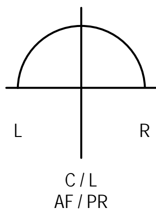
I have read the above information and have stated all my previous and current medical conditions. I take it upon myself to update the massage therapist regarding any changes in my condition. I understand that all massage treatments will be discussed an planned with the massage therapist and will require my informed consent.

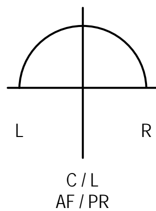
Signature: ______________ Date: ______________

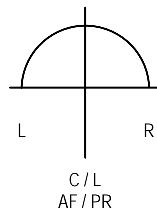
Ceinwen Gobert RMT Name: ______________________ Date: ______________________

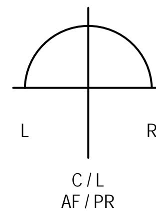
tension: //// trigger point: X tender point: o pain: ◯ adhesion: # parasthesia: ~ scars, bruises, wounds: +++

Spinal ROM









<u>UPDATED</u>

Date: ______________________ Client Signature: ______________________

Date: ______________________ Client Signature: ______________________

Date: ______________________ Client Signature: ______________________

Date: ______________________ Client Signature: ______________________

Ceinwen Gobert RMT **ONGOING TREATMENT FORM**

Client: ______________________

Therapist: ____________________

Date: ________________ Appt.Time: ___________ Duration: __________ Price: _________ Informed Consent: ❑ Yes ❑ No

Treatment (Tx) Areas: ____________________

Subjective: ____________________

Objective: ____________________

Assessment: ____________________

Techniques Used: ____________________

Post Tx Assessment: ____________________

Client Feedback ____________________

Tx Plan/Self-care: ____________________

Therapist: ____________________

Date: ________________ Appt.Time: ___________ Duration: __________ Price: _________ Informed Consent: ❑ Yes ❑ No

Treatment (Tx) Areas: ____________________

Subjective: ____________________

Objective: ____________________

Assessment: ____________________

Techniques Used: ____________________

Post Tx Assessment: ____________________

Client Feedback ____________________

Tx Plan/Self-care: ____________________