Living Well Health Centre

RMT Health History Form

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

Name: Phone #
Address:
Occupation: Date of Birth:
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 address.

Please indicate conditions you are experiencing or have experienced:

Cardiovascular
- ☐ high blood pressure
- ☐ low blood pressure
- ☐ chronic congestive heart failure
- ☐ heart attack
- ☐ phlebitis / varicose veins
- stroke/CVA
- pacemaker or similar device
- ☐ heart disease

is there a family history of any of the above? ☐ Yes ☐ No

Respiratory
- ☐ chronic cough
- ☐ shortness of breath
- ☐ bronchitis
- ☐ asthma
- ☐ emphysema

is there a family history of any of the above? ☐ Yes ☐ No

Infections
- ☐ hepatitis
- ☐ skin conditions
- ☐ TB
- ☐ HIV
- ☐ herpes

Other Conditions
- ☐ loss of sensation, where?
- ☐ diabetes, onset:
- ☐ allergies/hypersensitivity to what?

type of reaction:
- ☐ epilepsy
- ☐ cancer, where?
- ☐ skin conditions, what?
- ☐ arthritis

is there a family history of arthritis? ☐ Yes ☐ No

Head/Neck
- ☐ history of headaches
- ☐ history of migraines
- ☐ vision problems
- ☐ vision loss
- ☐ ear problems
- ☐ hearing loss

Women
- ☐ pregnant, due:
- ☐ gynaecological conditions, what?

Overall, how is your general health?

Primary Care Physician:

Address:

Current Medications:

condition it treats:

Are you currently receiving treatment from another health care professional? ☐ Yes ☐ No
If yes, for what?

Surgery – date
nature: ________________________________

Injury – date
nature:

Do you have any other medical conditions? (e.g. digestive conditions, haemophilia, osteoporosis, mental illness) ☐ Yes ☐ No
what?

Do you have any internal pins, wires, artificial joints or special equipment ? ☐ Yes ☐ No
what?
where?

What is the reason you are seeking massage therapy? Please include the location of any tissue or joint discomfort.

Notes:

Email address:______________________________

Signature: ______________________________
-
Date: ______________________________

Date of initial Health History:__________
Update 1 __________
Update 2 __________
Update 3 __________
Update 4 __________