



# Kleinburg Integrative Health

Naturopathy | Chiropractic | Massage | Nutrition | Psychology

10480 Islington Ave., Unit 10, Kleinburg, ON L0J 1C0

905.893.2898

Monday to Friday 9am to 7pm  
Saturday 9am to 3pm

## MASSAGE THERAPY HEALTH HISTORY FORM

Your health history information will help us treat you safely. All information you provide is strictly confidential, unless requested by law, and will need your extra written consent for any requested disclosures.

Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Occupation: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ Postal Code: \_\_\_\_\_

Home#: \_\_\_\_\_ Cell# / Work#: \_\_\_\_\_ Email: \_\_\_\_\_

Preferred Contact: \_\_\_\_\_ Emergency Contact Name: \_\_\_\_\_ Tel#: \_\_\_\_\_

Family Physician's Name: \_\_\_\_\_ Address: \_\_\_\_\_ Tel#: \_\_\_\_\_

Your General Health is? \_\_\_\_\_ Primary Complaint for Massage: \_\_\_\_\_

Have you ever had Massage Therapy? **Yes / No** Who Referred you? \_\_\_\_\_

Please **circle**  conditions you are **currently** experiencing, and **checkmark**  conditions **previously** experienced.

### **Soft Tissue / Joints:**

- Tendonitis / Bursitis
- Weakness
- Sprains / Strains / Spasm
- Arthritis: OA / RA / Other
- Herniated Spinal Disc
- Frozen Shoulder / Hip

### **Skin:**

Skin Condition(s): \_\_\_\_\_

- Bruise Easily
- Herpes
- Varicose Veins
- Athletes Foot
- Warts
- Plantar Warts
- Loss of Sensation

### **Headaches:**

- Tension Headache
- Migraine
- Tooth / Jaw / Ear pain
- Head trauma – date: \_\_\_\_\_

### **Respiratory:**

- Chronic cough
- Shortness of Breath
- Bronchitis
- Asthma
- Emphysema
- Pneumonia
- Sinus Problems

### **Cardiovascular:**

- High Blood Pressure
- Low Blood Pressure
- Heart Attack
- Phlebitis
- Stroke / CVA
- Pacemaker
- Heart Disease
- Angina
- Chronic Congestive Heart Failure

### **Accident / Injury :**

- Car Accident
- Whiplash
- Fractures
- Dates: \_\_\_\_\_

### **Other Conditions:**

Neurological Conditions: \_\_\_\_\_

Diabetes – onset: \_\_\_\_\_

Allergies: \_\_\_\_\_

anaphylaxis? Yes / No

Epilepsy

Cancer: \_\_\_\_\_

Vision Problems

Hearing Loss / Tinnitus

Constipation

Other Digestive Issues: \_\_\_\_\_

Insomnia

Kidney / Bladder Problems

Haemophilia

Fibromyalgia

Osteoporosis

Surgical Implants (pins, plates, wires)

### **Infectious Disease:**

Hepatitis

Tuberculosis

HIV / AIDS

Other: \_\_\_\_\_

**Women:** Pregnant – Due: \_\_\_\_\_ Gynecological Conditions: \_\_\_\_\_

**Any Other Medical Conditions?** \_\_\_\_\_

**Family History of Conditions:** \_\_\_\_\_

**Current medications:** \_\_\_\_\_

**Conditions it treats:** \_\_\_\_\_

**Previous surgeries / injuries:** \_\_\_\_\_

**Presence of internal pins, wires, metal plates:** \_\_\_\_\_

**Other Healthcare used?** Chiropractor / Physiotherapy / Naturopathic / TCM / Other: \_\_\_\_\_

### INFORMED CONSENT FOR TREATMENT

Massage Therapy is the manipulation of soft tissue of the skin, muscles, ligaments, tendons and connective tissues using various techniques and pressures to produce therapeutic results.

With Massage Therapy, the client disrobes to their comfort level and lies on a massage table between two sheets. The registered massage therapist will only drape one body region at a time that will be directly treated. Unscented oil is always used first and essential oils may also be used upon request.

If at any time you are uncomfortable with the oils, pressures or techniques being used during treatment, please tell the therapist as soon as you can so they can modify your treatment for you for your comfort. You may also stop the treatment at any time.

If you require treatment of any clinically sensitive areas (chest wall, breast tissue, gluteus muscles, upper and inner thigh muscles, **please initial** next to the clinically sensitive areas below to include in your treatment plans. You may withdraw consent at any time.

<p><u>(initial)</u> <u>Gluteus Muscles</u></p> <p><u>(initial)</u> <u>Chest Wall Muscles (pectoral muscles)</u></p> <p><u>(initial)</u> <u>Upper Thigh Muscles (quadriceps and hamstring muscles)</u></p> <p><u>(initial)</u> <u>Inner Thigh Muscles (adductor muscles)</u></p> <p><u>(initial)</u> <u>Breast(s) Tissue</u></p>
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“ I \_\_\_\_\_ (*Print Name*) \_\_\_\_\_, have read the above give my consent for ALL Registered Massage Therapists working at Kleinburg Integrative Health Clinic to move forward with the proposed treatment plan and include these clinically sensitive areas into my current and ALL treatments. Should I withdraw my consent or need to change my consent, I will let the clinic and R.M.T. know. I understand that I can do this at any time. If I need to change my health history as well, I understand I may do so by letting the clinic or R.M.T. know. I understand that there is a **24 hours cancellation/rescheduling policy**. If I miss a treatment or do not give enough notice, I understand a full treatment fee will be charged.

**Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

Updates: \_\_\_\_\_