

Jennifer E. Revelle RMT

519-426-4275

www.armstrongclinic.com

Please complete this Health History form as accurately as possible. These three pages will help to ensure that you receive safe and effective treatment. If at any time your health status changes, please let me know as soon as possible prior to your treatment. All information is strictly confidential and cannot be released to anyone without your written consent. If at any time you have any questions, please feel free to ask.

Name: _____

Address: _____

City: _____ Postal Code: _____

Phone (H) _____ (W) _____ Cell _____

Email : _____

Age _____ Date of Birth: _____ Ht: _____ Wt: _____

Occupation: _____

Family Physician: _____ Phone _____

Reason for Treatment today: _____

How/Where did you hear about this clinic? _____

Have you ever had Massage Therapy before? (please include reason for previous treatment):

Head and Neck

___ Headache
Type _____
___ Dizziness
___ Earaches
___ Sinus Problems

Muscle & Joint

___ Pain
___ Stiffness
___ Swelling
___ Limited Motion
___ Fatigue
___ Osteoarthritis
___ Rheumatoid Arthritis
___ Back Pain
Upper ___ Mid ___ Lwr ___
___ Shoulder Pain

Women

Menstruation
___ Painful
___ Heavy
___ Light
___ Normal
___ Irregular
___ Absent
___ Pregnant
___ Children# ___
___ Menopause
___ Hysterectomy

Respiratory

___ Chronic Cough
___ Shortness of Breath
___ Asthma
___ Bronchitis
___ Emphysema

Skin

___ Sensitive Skin
___ Rashes
___ Acne
___ Cold Sores
___ Bruise Easily
___ Varicose Veins
___ Deep Vein Thrombosis
___ Eczema/Psoriasis
___ Recent Tattoos
___ Recent Piercing
___ Recent Stitches

Cardiovascular

___ High Blood Pressure
___ Low Blood Pressure
___ Poor Circulation
___ Heart Surgery
___ Heart Disease
___ Pacemaker
___ Stroke

Digestive

___ Poor Digestion
___ IBS
___ Diarrhea
___ Constipation
___ Difficult Digestion
___ Liver/Gallbladder
___ Kidney/Bladder

Other

___ Epilepsy
___ Vision Problems
___ Vertigo
___ Hearing Loss
___ Ear (infection/tubes)
___ Hepatitis – Type ___
___ HIV ___ TB

General Health Status

___ Good
___ Average
___ Poor

General Stress Levels

___ High
___ Moderate
___ Low

Diet

___ Regular Meals
___ Irregular Eating
___ Caffeine
___ Smoke
Pkg(s)/day _____

Exercise

___ Regular
___ Occasional
___ Little
___ None

Previous Health Care

___ Massage Therapy
___ Chiropractic
___ Physiotherapy
___ Acupuncture
___ Osteopathy
___ Psychotherapy

Date of last full physical

Allergies _____

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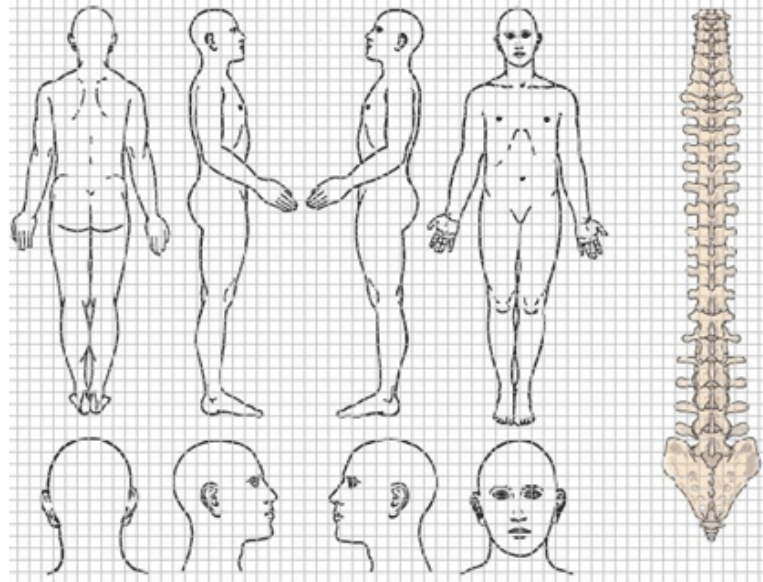
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Current prescription medications and reason for use:

Date and nature of any accidents or surgeries:

Of Special Note: (Pins, Wires, Prosthetics, Walker, Cane etc.)

Please use diagram below to indicate areas of pain/discomfort/issues to address



Please use this area for any additional information or details _____

I have completed this form to the best of my knowledge and will inform my therapist of any changes in my physical health and/or medications or supplements.

Signature _____ Date: _____

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Massage Therapy Consent Form

Please read carefully! This record of consent is required before any treatment can be provided. Massage Therapy includes the assessment and treatment of soft tissues and joints of the body, by means of any, or some of, the following: soft tissue manipulations, joint mobilization, hydrotherapy, remedial exercise programs, and directed self-care programs. The client reserves the right to stop or alter the treatment, regardless of prior consent.

Massage Therapy fees are as follows:

1 hour treatment	\$70 + hst
¾ hour treatment	\$55 + hst
½ hour treatment	\$40 + hst

Wisdom Rate (65 years and over)

1 hour treatment	\$65 + hst
¾ hour treatment	\$51.25 + hst
½ hour treatment	\$37.50 + hst

Cancellation and Missed Appointment Policy

24 hours notice is required in order to cancel or reschedule a massage therapy appointment. If the client is unable to provide sufficient notice, the client will be **billed in full** for their cancelled or missed appointment.

Privacy Policy

All massage therapy treatments, information, and records will remain confidential unless written consent is provided by the client. The client also reserves the right to review their personal information at any time. The client acknowledges that reception staff may need to contact the client with regards their scheduled massage therapy treatments.

Health History and Update Status

The client will provide all relevant known health history information, and will notify their therapist of any changes health status.

Printed Name

Signature

Date