# Health History Form: Registered Massage Therapy or Osteopathic Manual Treatment

The information requested below will assist us in contacting you and treating you safely. Feel free to ask any questions you may have about the information being requested. We send out emails to remind you of appointments, and very occasionally for promotions. All information provided to us here and in your treatment will be kept confidentially unless allowed by you or required by law. Your written permission will be required to release this information.

Name       Date of Birth:         Address	Name		Date of Birth:			
E-Mail Address       Occupation         How did you hear about Elysis?       Google Yahoo Other:         Have you ever had Massage Therapy/Osteopathy before?	Address	CityPostal Code				
E-Mail Address       Occupation         How did you hear about Elysis?       Google Yahoo Other:         Have you ever had Massage Therapy/Osteopathy before?	Daytime Ph. #	(Work/ho	ome/cell?) Alt. Ph_	(Work/home/cell?)		
How did you hear about Elysis?       Google Yahoo Other:         Have you ever had Massage Therapy/Osteopathy before?         Please check all conditions that apply to you now or in the past         Cardiovascular       Infections         Image: hyperbox of pressure       Head/Neck         Instroy of headaches       history of headaches         Involted pressure       skin conditions:       history of headaches         Involted pressure       skin conditions:       vision problems         Involted pressure       skin conditions:       vision loss         Involted pressure       herepes       ear problems         Involted pressure       betrefitivaricose veins       herepes         Involted pressure       Other Conditions       hearing loss         Involted pressure       Diabetes, onset:       Grancen         Involted pressure       Diabetes, onset:       Grancer         Involted pressure       Arthritis: OA, RA, JRA       Physician Address:         Involted pressure       Family history of arthritis?       Physician Address:         Involted pressure       Family history of arthritis?       Physician Address:         Involtion it treats       Why are you seeking massage therapy? Please include the location of and tissue or joint discomfort.         Involtions, hemophilia, osteoporos	E-Mail Address		Occupation	1		
Have you ever had Massage Therapy/Osteopathy before?	How did you hear about Elysis? Goo	gle Yahoo Othe	r:			
May we ask why you chose to give us a try?       Please check all conditions that apply to you now or in the past         Cardiovascular       Infections            ingh blood pressure       Head/Neck            ingh blood pressure       skin conditions:            chronic congestive heart failure       TB            heart atack       HIV            phebitis/varicose veins       herpes            pacemaker or similar device       tingling or loss of sensation. Where?            heart disease       Diabetes, onset:            chronic cough       Atlergies/sensitivity. To what?            shortnes of breath       Diabetes, onset:            shortnes of breath       Caccer            emphysema       Carcer            chronic tree professional? Yes / No What?       Why are you seeking massage therapy? Please include the location of and tissue or joint discomfort.            reare professional? Yes / No What?       Please is any surgeries or injuries below:            Do you have any other medical conditions?       Pleage distany surgeries or injuries below:            Do you have any internal pins, wires, or artificial joints or special equipment? Yes / No       Please list any surgeries or injuries below:            Event:       Date:       Date:						
Please check all conditions that apply to you now or in the past         Cardiovascular       Infections       Hepatitis       Isitory of headaches         high blood pressure       bistory of migraines       bistory of migraines       bistory of migraines         chronic congestive heart failure       TB       vision problems       vision problems         phelbitis/varicose veins       herpes       car problems       hearting loss         stroke/CVA       Other Conditions       hearting loss       hearting loss         espiratory       Diabetes, onset:       Gynecological conditions:       Gynecological conditions:         ohrtneic cough       Atheritis: OA, RA, JRA       Physician Phone Number:       Gynecological conditions:         asthma       Cancer       Physician Address:       Physician Address:       Physician Address:         dasthma       Cancer       Shothris: OA, RA, JRA       Physician Address:       Physician Address:         family history of arthrits:       Why are you seeking massage therapy? Please include the location of and tissue or joint discomfort.       Shothress         is it helping? Yes / No / Unsure       Phease list any surgeries or injuries below:       Please list any surgeries or injuries below:         Do you have any other medical conditions? (eg. digestive condition:       Please list any surgeries or injuries below:	May we ask why you chose to give us	a try?				
□       high blood pressure       □       Hepatitis       □       history of headaches         □       bw blood pressure       □       skin conditions:       □       history of migraines         □       chronic congestive heart failure       □       Itstory of migraines       □       history of migraines         □       heart attack       □       HIV       □       vision problems         □       heart of semilar device       □       tingling or loss of sensation. Where?       □       hearing loss         □       pacemaker or similar device       □       Diabetes, onset:       □       Pregnancy, Due:       □         □       chronic cough       □       Itstory of arthritis: OA, RA, JRA       Physician Phone Number:       □         □       shthma       □       Cancer       Physician Address:       Physician Address:       Physician Address:         □       cancer       □       Gardression of arthritis: OA, RA, JRA       Physician Address:       □         □       care professional? Yes / No What?	Please check all conditions that apply to you now or in the past					
□ low blood pressure       □ skin conditions:       □ history of migraines         □ hornoic congestive heart failure       □ TB       □ vision problems         □ heart attack       □ HIV       □ strok/CVA         □ phtlebilis/varicose veins       □ herpes       □ a problems         □ bacemaker or similar device       □ ingling or loss of sensation. Where?       □ Gynecological conditions:         □ heart discase       □ Diabetes, onset:       □ Gynecological conditions:         □ chronic cough       □ Allergies/sensitivity. To what?       □ Gynecological conditions:         □ bronchitis       □ Epilepsy       □ Gynecological conditions:         □ softmaa       □ Cancer       Physician Address:         □ emphysema       □ Arthritis: OA, RA, JRA       Physician Address:         □ remeter signal? Yes / No What?       □ Stroker Yes / No What?       Physician Address:         □ si th helping? Yes / No / Unsure       Why are you seeking massage therapy? Please include the location of and tissue or joint discomfort.         □ you have any other medical conditions? (eg. digestive conditions, hemophilia, osteoporosis, anxiety) Yes / No       Please list any surgeries or injuries below::         □ you have any internal pins, wires, or artificial joints or special equipment? Yes / No       □ Date:       □ Date:         □ byou have any internal pins, wires, or artificial joints or special equipment? Yes	Cardiovascular	Infections		Head/Neck		
□ low blood pressure       □ skin conditions:       □ history of migraines         □ hornoic congestive heart failure       □ TB       □ vision problems         □ heart attack       □ HIV       □ strok/CVA         □ phtebilis/varicose veins       □ herpes       □ a problems         □ bacemaker or similar device       □ lingling or loss of sensation. Where?       □ Gynecological conditions:         □ heart discase       □ Diabetes, onset:       □ Gynecological conditions:         □ chronic cough       □ Allergies/sensitivity. To what?       □ Gynecological conditions:         □ bronchitis       □ Epilepsy       □ Gynecological conditions:         □ softmaa       □ Cancer       Physician Phone Number:         □ asthma       □ Cancer       Physician Address:         □ emphysema       □ Arthritis: OA, RA, JRA       Physician Address:         □ ramily history of arthritis?       Why are you seeking massage therapy? Please include the location of and tissue or joint discomfort.         □ ramily nistory fees/No / Unsure       □       □         Do you have any other medical conditions? (eg. digestive condition, hemophilia, osteoporsis, anxiety) Yes / No       Please list any surgeries or injuries below:         Condition:       □       □       □         Do you have any other medical conditions?       [eyent:       Date: </td <td>□ high blood pressure</td> <td colspan="2">□ Hepatitis</td> <td>□ history of headaches</td>	□ high blood pressure	□ Hepatitis		□ history of headaches		
□ heart attack       □ HIV       □ vision loss         □ hebbits/varicose veins       □ herpes       □ ear problems         □ stroke/CVA <b>Other Conditions</b> □ hearing loss         □ pacemaker or similar device       □ tingling or loss of sensation. Where?       □ Gynecological conditions:         □ heart disease       □ Diabetes, onset:       □ Gynecological conditions:         □ chronic cough       □ Allergies/sensitivity. To what?       □ Gynecological conditions:         □ shortness of breath       □ Epilepsy       □ Physician Phone Number:         □ asthma       □ Cancer       Physician Address:         □ emphysema       □ Arthritis: OA, RA, JRA       Physician Address:         □ family history of arthritis?       Vhy are you seeking massage therapy? Please include the location of and tissue or joint discomfort.         □ art reprofessional? Yes / No / Unsure       □       □         Do you have any other medical conditions? (eg. digestive conditions, lemophilia, osteoporosis, anxiety) Yes / No       □         Do you have any internal pins, wires, or artificial joints or special equipment? Yes / No       □         What?						
□       phlebitis/varicose veins       □       herpes       □       ear problems       □       hearing loss         □       pacemaker or similar device       □       tingling or loss of sensation. Where?       □       Pregnancy, Due:       □       □       Pregnancy, Due:       □       □       Gynecological conditions:       □       □       □       Opponentions       □       □       Gynecological conditions:       □       □       □       □       Gynecological conditions:       □       □       □       Gynecological conditions:       □       Gynecological conditions:       □       Diabets, onset:       □       □       Gynecological conditions:       □       Gynecological conditions:       □       Gynecological conditions:       □       Frimary Care Physician:       □       Diabets, onset:       □       Frimary Care Physician:       □       Gynecological conditions:       □       Gynecological conditions:       □       Gynecological conditi	□ chronic congestive heart failure	□ TB		$\Box$ vision problems		
□ stroke/CVA       Other Conditions       □ hearing loss         □ bacemaker or similar device       □ tingling or loss of sensation. Where?       □ hearing loss         □ bant disease       □ Diabetes, onset:       □ Gynecological conditions:       □ Gynecological conditions:         □ bronchitis       □ Epilepsy       □ Shortness of breath       □ Gynecological conditions:       □ Gynecological conditions:         □ shortness of breath       □ Epilepsy       □ Allergies/sensitivity. To what?       □ Physician Phone Number:       □ Gynecological conditions:         □ sthma       □ Cancer       □ Arthritis: OA, RA, JRA       □ Physician Address:       □ Physician Address:         Current medications / Condition it treats       □ Family history of arthritis?       Why are you seeking massage therapy? Please include the location of and tissue or joint discomfort.         □ are professional? Yes / No What?       □       □       □         □ by you have any other medical conditions? (eg. digestive conditions, hemophilia, osteoporosis, anxiety) Yes / No Condition:       □       □         Do you have any internal pins, wires, or artificial joints or special equipment? Yes / No       Please list any surgeries or injuries below:       Event:       Date:         Do you have any internal pins, wires, or artificial joints or special equipment? Yes / No       Event:       Date:       Date:	□ heart attack	□ HIV		□ vision loss		
pacemaker or similar device       tingling or loss of sensation. Where?       Women         heart disease	□ phlebitis/varicose veins	□ herpes		$\square$ ear problems		
□ heart disease       □	□ stroke/CVA	Other Conditions		□ hearing loss		
Respiratory <ul> <li>Diabetes, onset:</li> <li>Chronic cough</li> <li>Allergies/sensitivity. To what?</li> <li>Primary Care Physician:</li> <li>Physician Phone Number:</li> <li>Physician Address:</li> </ul> asthma       Cancer       Physician Address:       Physician Address:         current medications / Condition it treats       Physician Address:       Physician Address:         durrent medications / Condition it treats       Why are you seeking massage therapy? Please include the location of and tissue or joint discomfort.         durrent medications / Condition it treats       Why are you seeking massage therapy? Please include the location of and tissue or joint discomfort.         durrent medications / No What?       Image: Second Conditions (eg. digestive conditions, hemophilia, osteoporosis, anxiety) Yes / No       Please list any surgeries or injuries below:         bo you have any other medical conditions? (eg. digestive conditions, hemophilia, osteoporosis, anxiety) Yes / No       Please list any surgeries or injuries below:         Do you have any internal pins, wires, or artificial joints or special equipment? Yes / No       Event:       Date:         what?       Image: Second Equipment? Yes / No       Image: Second Event:       Date:         Mate:	pacemaker or similar device	$\Box$ tingling or loss of sensation. Where?				
Chronic cough       Allergies/sensitivity. To what?       Primary Care Physician:         shortness of breath       Epilepsy       Physician Phone Number:         asthma       Cancer       Physician Address:         emphysema       Arthritis: OA, RA, JRA       Physician Address:         Current medications / Condition it treats       Why are you seeking massage therapy? Please include the location of and tissue or joint discomfort.	□ heart disease			□ Pregnancy, Due:		
□       shortness of breath       □       Epilepsy       Physician Phone Number:         □       asthma       □       Cancer       Physician Address:         □       emphysema       □       Arthritis: OA, RA, JRA       Physician Address:         □       Family history of arthritis?       Why are you seeking massage therapy? Please include the location of and tissue or joint discomfort.		Diabetes, onset:				
□       bronchitis       □       Epilepsy       Physician Phone Number:         □       asthma       □       Cancer       Physician Address:         □       anthritis: OA, RA, JRA       Physician Address:       Physician Address:         Current medications / Condition it treats       Why are you seeking massage therapy? Please include the location of and tissue or joint discomfort.		□ Allergies/sensitivity. To what?		Primary Care Physician:		
asthma       Cancer       Arthritis: OA, RA, JRA       Physician Address:         Current medications / Condition it treats       Why are you seeking massage therapy? Please include the location of and tissue or joint discomfort.         Are you currently receiving treatment from another health care professional? Yes / No       Why are you seeking massage therapy? Please include the location of and tissue or joint discomfort.         Is it helping? Yes / No / Unsure       Image: Conditions? (eg. digestive conditions, hemophilia, osteoporosis, anxiety) Yes / No       Please list any surgeries or injuries below:         Do you have any internal pins, wires, or artificial joints or special equipment? Yes / No       Please list any surgeries or injuries below:         Event:       Date:         Event:       Date:	$\Box$ shortness of breath					
Image: maphysema       Image: Arthritis: OA, RA, JRA       Physician Address:         Image: Family history of arthritis?       Image: Marking and the state	□ bronchitis	□ Epilepsy		Physician Phone Number:		
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Current medications / Condition it treats       Why are you seeking massage therapy? Please include the location of and tissue or joint discomfort.         Are you currently receiving treatment from another health care professional? Yes / No What?	□ emphysema	□ Arthritis: OA, RA, JRA		Physician Address:		
		□ Family history of arthritis?				
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care professional? Yes / No What?			iocation of and tiss	de of joint disconnort.		
care professional? Yes / No What?	Are you currently receiving treatment from another health					
Is it helping? Yes / No / Unsure         Do you have any other medical conditions? (eg. digestive conditions, hemophilia, osteoporosis, anxiety) Yes / No         Condition:         Do you have any internal pins, wires, or artificial joints or special equipment? Yes / No         What?						
Do you have any other medical conditions? (eg. digestive conditions, hemophilia, osteoporosis, anxiety) Yes / No						
Do you have any other medical conditions? (eg. digestive conditions, hemophilia, osteoporosis, anxiety) Yes / No						
Do you have any other medical conditions? (eg. digestive conditions, hemophilia, osteoporosis, anxiety) Yes / No	Is it helping? Yes / No / Unsure					
conditions, hemophilia, osteoporosis, anxiety) Yes / No       Please list any surgeries or injuries below:         Condition:       Please list any surgeries or injuries below:         Do you have any internal pins, wires, or artificial joints or special equipment? Yes / No       Please list any surgeries or injuries below:         Event:       Date:         Event:       Date:         Event:       Date:         Event:       Date:         Event:       Date:						
conditions, hemophilia, osteoporosis, anxiety) Yes / No       Please list any surgeries or injuries below:         Condition:       Please list any surgeries or injuries below:         Do you have any internal pins, wires, or artificial joints or special equipment? Yes / No       Please list any surgeries or injuries below:         Event:       Date:         Event:       Date:         Event:       Date:         Event:       Date:         Event:       Date:	Do you have any other medical conditions? (eg. digestive					
Condition:       Please list any surgeries or injuries below:         Do you have any internal pins, wires, or artificial joints or special equipment? Yes / No       Please list any surgeries or injuries below:         Event:       Date:         Event:       Date:         Event:       Date:         Event:       Date:         Event:       Date:         Event:       Date:						
Do you have any internal pins, wires, or artificial joints or special equipment? Yes / No       Event:       Date:       Date:         What?			Please list any surgeries or injuries below:			
Do you have any internal pins, wires, or artificial joints or special equipment? Yes / No       Event:       Date:         What?       Event:       Date:			Event:Date:			
special equipment? Yes / No     Event:     Date:       What?     Event:     Date:	Do you have any internal pins, wires, or artificial joints or		Event:	Date:		
What?   Event:   Date:			Event:	Date:		
Where?      Date:	What?		Event:	Date:		
	Where?		Event:	Date:		

### How would you consider your current health:

## Consent For Receiving: Registered Massage Therapy or Osteopathic Manual Treatment

Please read the following and acknowledge your consent below. Without your signature of consent, your therapist is not allowed to provide Massage Therapy/Osteopathic Treatment to you. Please ask any questions you may have about the information below if it is not clear.

- 1. Massage therapy or Osteopathic Treatment is given when your RMT/D.O.M.P. expects it to provide you with therapeutic results.
- 2. One of the main goals of an RMT/D.O.M.P. is to increase the circulation to tissues being treated thereby decreasing the muscle tone of the muscles being treated, and symptoms you may be experiencing.
- 3. Risks for receiving treatment are determined after your RMT/D.O.M.P. looks over your health history form for any specific problems. Your therapist will take steps to minimize any possible risks associated with your treatment, or refer you to another health care professional in the case that this is not possible.
- 4. Common side effects of Massage Therapy/Osteopathic Treatment include dizziness/light headedness while getting off the table, and tenderness in the areas treated following your treatment.
- 5. Alternatives to Massage Therapy/Osteopathic Treatment may include a home stretching or exercise program, hot or cold hydrotherapy, and/or therapy with another health care professional which your therapist may recommend to you.
- 6. Clothing may be kept on or removed for the massage as per your comfort level (Massage Therapy). Only the areas to be treated will be visible, all other areas will remain covered during your treatment. You will not be inappropriately exposed by your RMT.
- 7. RMTs are trained to use swedish massage techniques, and individual RMTs may have additional training such as Cranial Sacral therapy or other modalities or techniques as their careers progress. Your RMT/D.O.M.P. will only provide therapy to you that is within their scope of practice and for which they have received proper formal training.
- 8. If at any time you wish for your Massage treatment/Osteopathic treatment to be modified, you have every right to request what you need. It's your body, and your therapist will respect that and work with you to assist you.
- 9. Our therapists use advanced massage therapy techniques when indicated for your treatment.
- 10. Information is shared within "Elysis" between therapists to better assist and care for your health. For this reason, your treatment notes, health history, and any other documentation related to your personal health information you provide may be read or used by another therapist if you request to see them for treatment.

I agree that I understand all of the above and have been given the chance to ask any questions related to the treatment proposed by my RMT/D.O.M.P. . I give my full consent for receiving Massage Therapy/Osteopathic Manual Therapy.

#### **Cancellation Policy**

Out of fairness to your therapist and other clients trying to see your therapist, we require minimum 24 hours notice for all the cancellations. For missed appointments, or cancellations less than 24 hours in advance, you will be required to cover the full cost of your appointment.

### **Sick Cancellation Policy**

If you are sick with any communicable illnesses, in any stage of illness, please cancel your appointment and reschedule for another date. This is for the protection of your therapist and for our other clients with compromised immune systems. If you come to your appointment while showing signs and symptoms of illness, your therapist will help you reschedule at that time.

Signature:\_\_\_\_\_

Printed Name:	
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Date:\_\_\_\_\_