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_____ City_____ Postal Code_____
Daytime Ph. #_____(Work/home/cell?) Alt. Ph_____ (Work/home/cell?)
E-Mail Address_____ Occupation_____
How did you hear about Elysis? Google Yahoo Other:_____
Have you ever had Massage Therapy/Osteopathy before? _____
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
- ☐ high blood pressure
- ☐ low blood pressure
- ☐ chronic congestive heart failure
- ☐ heart attack
- ☐ phlebitis/varicose veins
- ☐ stroke/CVA
- ☐ pacemaker or similar device
- ☐ heart disease

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

Infections
- ☐ Hepatitis
- ☐ skin conditions:_____
- ☐ TB
- ☐ HIV
- ☐ herpes

Other Conditions
- ☐ tingling or loss of sensation. Where? _____
- ☐ Diabetes, onset:_____
- ☐ Allergies/sensitivity. To what? _____
- ☐ Epilepsy
- ☐ Cancer
- ☐ Arthritis: OA, RA, JRA
- ☐ Family history of arthritis?

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

Women
- ☐ Pregnancy, Due:_____
- ☐ Gynecological conditions:_____

Primary Care Physician:
_____
Physician Phone Number:
_____
Physician Address:
_____

Current medications / Condition it treats
_____
_____

Are you currently receiving treatment from another health care professional? Yes / No What?_____
_____

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?_____
Where?_____

Why are you seeking massage therapy? Please include the location of and tissue or joint discomfort.
_____
_____
_____
_____
_____
_____
_____
_____
_____

Please list any surgeries or injuries below:
Event:_____Date:_____
Event:_____Date:_____
Event:_____Date:_____
Event:_____Date:_____
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:_____

Date:_____