Bayview Village Wellness Centre
2901 Bayview Ave. Professional Offices Ste 201
North York, ON M2K 1E6 416-221-7724

HEALTH HISTORY FORM

This health history is important in order to gather enough information to ensure that it is safe for you to receive a massage treatment. Please be accurate and thorough when completing this form and if your health status changes in the future, please inform your therapist. All information obtained for this treatment and subsequent visits will be kept in your file and is *completely confidential,* except as required or allowed by law. You will be asked to provide written authorization for release of any information.

Client Information:

Name: _____ Date of Birth: ___/ ___/ ___(dd/ mm/ yy) Phone # (Home): _____-_____-_____
Address: _____ City/ Town: _____ Province: _____ Postal Code: _____
Occupation: _____ Phone # (Bus): _____-_____-_____ Phone# (Cell): _____-_____-_____
email: _____ General Health Status: _____
Physician's Name: _____ Physician's Phone # : _____-_____-_____ Physician's address: _____
Have you ever had a professional massage before? Yes / No
In case of emergency contact: _____ Phone # : _____-_____-_____ Relationship: _____

How did you hear about us? (Please circle): internet yellow pages newspaper/ magazine ad Other: _____
Friend/ colleague: _____ Doctor: _____

***Medical History*:** Please indicate the conditions that you are currently experiencing or have previously experienced in the past.

RESPIRATORY	**Current**	**Previous**
Chronic cough		
Shortness of Breath		
Bronchitis		
Asthma		
Emphysema		
Other:_____		
Do you have a puffer?		
Do you smoke?		
CARDIOVASCULAR	**Current**	**Previous**
High Blood Pressure		
Low Blood Pressure		
High Cholesterol		
Poor Circulation		
C. C. H. F.		
Heart Attack		
Heart Disease		
Stroke/CVA		
Atherosclerosis		
Varicose Veins		
Phlebitis		
Deep Vein Thrombosis		
Hemophilia		
Other:_____		
DIGESTION	**Current**	**Previous**
Difficult Digestion		
Irritable Bowel Syndrome		
Constipation		
Diarrhea		
Gall Stones		
Kidney Stones		
Appendicitis		
Urinary Disorder		
Stomach Ulcer		
Other:_____		
WOMEN	**Current**	**Previous**
Menstrual Problems		
Pregnant: Due __/__/__ (dd/mm/yy)		
Menopausal Post menopausal		

NERVOUS SYSTEM	**Current**	**Previous**
Multiple Sclerosis		
Parkinson's		
Epilepsy		
A.L.S. (Lou Gehrig's Disease)		
Seizures		
Meningitis		
Polio		
Loss of sensation/motor skill		
Other:_____		
SKIN	**Current**	**Previous**
Bruise Easily		
Dermatitis		
Acne		
Warts		
Infectious Skin Condition		
INFECTIONS	**Current**	**Previous**
HIV/AIDS		
STD:_____		
Hepatitis		
Herpes		
Tuberculosis		
Other:_____		
OTHER CONDITIONS	**Current**	**Previous**
Diabetes		
Hypoglycemia		
Sinusitis		
Insomnia		
Cancer:_____		
Arthritis:_____		
Hernia:_____		
Fibromyalgia		
Lupus Erythematosus		
Vertigo		
TMJ Dysfunction		
Vision Loss		
Hearing Loss		
Allergies/hypersensitivities		
Other conditions/diseases/skin irritations/anaphalaxis		

Family History: Many health conditions can be hereditary or familial. Any information that you can provide about your family may be helpful in assessing your condition.

RELATIONSHIP	CONDITION

Of Special Note: Please list any special equipment you have in order to carry out activities (ie. pins, screws, wires, pacemaker, artificial joints or limbs, wheelchair, cane, walker, dentures, glasses, contact lenses, hearing aid, etc).

_____
_____
_____
_____
_____

Injury:

TYPE OF INJURY	DATE	CURRENT SYMPTOMS

Surgery:

TYPE OF SURGERY	DATE	CURRENT SYMPTOMS

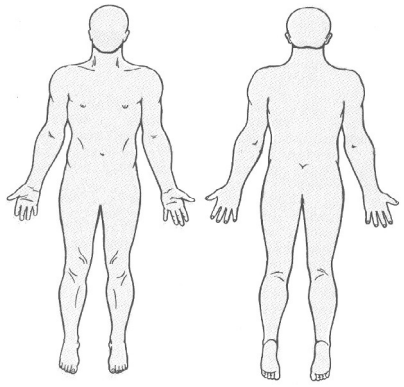
Current Medications:

NAME:	FOR WHAT CONDITION:

Primary Complaint: _____

Area of focus: Please check off which area(s) are causing you pain and/or stiffness in the chart below and indicate on the diagram to the right.

Head (ie. headache, migraine)	
Neck	
Shoulders	
Upper Back	
Mid-Back	
Lower Back	
Leg: left / right	
Knee: left / right	
Ankle: left / right	
Arm: left / right	
Elbow: left / right	
Wrist: left / right	
Other:	



Other Health Care: Please indicate below any other health care practices that you currently use.

Chiropractic		Reflexology	
Naturopathy		Nutritional Therapy	
Osteopathy		Physiotherapy	
Other:			

Lifestyle Activities: Please list any extra curricular activities/hobbies/interests that you partake in (ie. sports, regular exercise, etc).

_____
_____

Thank you for filling out this form, please sign & date here: _____Date: _____

OFFICE USE ONLY

Case History Information Updates:

Date (dd/mm/yy)	Signature
____/____/____	_____
____/____/____	_____
____/____/____	_____

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OFFICE POLICY

- As Registered Massage Therapists, we are obligated by the College of Massage Therapists of Ontario to abide by a Scope of Practice: "The practice of massage therapist is the assessment of the soft tissue and joints of the body and the treatment and prevention of physical dysfunction and pain of the soft tissues and joints by manipulation to develop, maintain, rehabilitate or augment physical function, or relieve pain."
- It is required by law to have you complete a health history form to be kept in our records. Please be aware that you do have access to your file at any time, and your information will be kept confidential, except as required or allowed by law. If you are also a patient of chiropractic and/or acupuncture, your information may be exchanged between Doctors in order to benefit your treatment goals. You will be asked to provide written authorization on a separate consent form for the release of any information.
- Please inform us prior to future massage treatments if your health status changes at any given time, this will help us to adapt our treatment to your individual needs. Please also be aware that we are obligated to update your health information annually.

CANCELLATION POLICY

Our cancellation policy is as follows:

- Notification of cancellation up to 6 hours before massage treatment: there will be no charge.
- **No notification or less than 6 hours notification of cancellation before massage treatment: there will be a charge of 1/2 of the treatment cost charged to your credit card on file.**
- Please note that we do 24-hour reminder calls before your massage appointment, however, this is only a courtesy, you are still responsible for attending your massage at the scheduled time & date.

_____ _____ _____

(Print name) (Signature) (Date)