Massage Therapy

HealthTweak

Patient # ____________

PERSONAL INFORMATION

Name: ______________________ Date of Birth: ____________ Age: ________

Address: ______________________ City: ____________ Postal Code: ____________

Home Phone: ______________________ Cell: ____________ Work Phone: ____________

Gender: ____________ Employer: ______________________ Occupation: ____________

E-mail: ______________________ May we contact you via e-mail? Y / N

Spouse/Partner: Y / N Children: Y / N #: ________

Medical Doctor: ______________________ Location: ____________ Last Visit: ____________

How did you hear about us? ☐*Existing patient* ______________________

☐*Online* ☐ *Doctor* ☐*Other:*__________

HEALTHCARE HISTORY

Have you ever seen? ☐ Chiropractor ☐ Physiotherapist ☐ Massage Therapist ☐ Naturopath

Date of last visit: ____________ ____________ ____________ ____________

Have you ever had? ☐ X- Ray ☐ MRI ☐ CT ☐ Ultrasound

WHAT IS THE NATURE OF YOUR VISIT?

☐ Wellness (help me to always be at the highest level of health)

☐ Restorative (help me to restore my health)

☐ Injury (help me to get out of pain)

Please explain your health challenges in order of importance to you:

1) ____

When did it begin? ______________________ Have you had this problem before? ____________

This challenge started: ☐ Suddenly ☐ Gradually ☐ Unknown

Have you noticed any other symptoms associated with this challenge? ____________

What does this challenge stop you from doing? ______________________

Have you seen anyone about this challenge? ______________________

Prior treatments and results? ______________________

2) ____

When did it begin? ________________ Have you had this problem before? ____________

This challenge started: ☐ Suddenly ☐ Gradually ☐ Unknown

Have you noticed any other symptoms associated with this challenge? ________________

What does this challenge stop you from doing? ______________________________

Have you seen anyone about this challenge? ________________________________

Prior treatments and results? ____

3) ____

When did it begin? ________________ Have you had this problem before? ____________

This challenge started: ☐ Suddenly ☐ Gradually ☐ Unknown

Have you noticed any other symptoms associated with this challenge? ________________

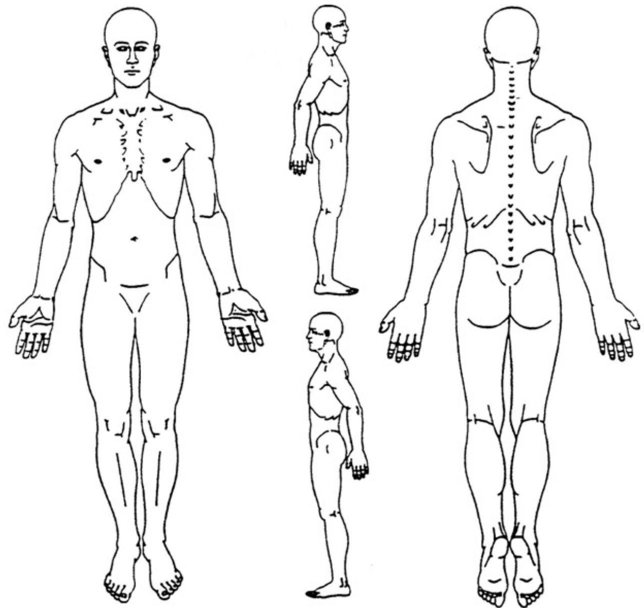
What does this challenge stop you from doing? ______________________________

Have you seen anyone about this challenge? ________________________________

Prior treatments and results? ____

Use letters to indicate type and location of discomfort:

A = Ache
B = Burning
S = Stabbing
N = Numbness
P = Pins & Needles



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HEALTH INFORMATION

Past injuries: (birth complication, teen trauma, emotional trauma, severe stress, injuries, work injuries, car accidents, surgeries, broken bones, etc)

Emotional trauma: ____

Chemical trauma: ____

Physical trauma: ____

Surgeries/Hospitalizations: ____

Health conditions treated for in the past year:

____

____

Medication and Supplements

Please list any *medications* you are taking: *Purpose and dose*:

______________________ ______________________

______________________ ______________________

______________________ ______________________

______________________ ______________________

Please list any *supplements* you are taking: *Purpose and dose*:

______________________ ______________________

______________________ ______________________

______________________ ______________________

______________________ ______________________

Gynecology and Pregnancy

Age of first period: ____________ Any chance you may be pregnant? Y N If so, # of weeks______

First day of your last period? ______________ How long does your period last? ____________________

How long is your cycle (first day of menses to last day before they start again)? ____________________

Are your menses? Irregular Painful Heavy

Do you experience hot flashes? Y N

Date of last PAP : _________________ Normal cells Abnormal cells

Are you using any method of birth control? If yes, what type?______________________________

How long have you been using this method? ____

Do you experience any changes with your body or emotions prior to your menses/period or at any specific point in your cycle? ____

Have you ever been pregnant? If yes;

# of live pregnancies ___________ # of miscarriage ______________ # of abortions ________________

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HEALTH CONDITIONS

Please check the following that apply to you:

- ☐ Seizures
- ☐ Allergies _____________
- ☐ HIV
- ☐ Rheumatoid Arthritis
- ☐ Diabetes
- ☐ Alcoholism
- ☐ Thyroid Disease
- ☐ Cystic Fibrosis
- ☐ Heart Disease
- ☐ Hepatitis
- ☐ Arthritis
- ☐ Other Major Illness
- ☐ Rheumatic Fever
- ☐ Cancer
- ☐ Venereal Disease

General

- ☐ Loss of appetite
- ☐ Weight loss
- ☐ Weight gain
- ☐ Night sweats
- ☐ Nausea/vomiting
- ☐ Fevers
- ☐ Lumps
- ☐ Masses
- ☐ Dizziness
- ☐ Double vision
- ☐ Problems swallowing
- ☐ Problems talking
- ☐ Loss of consciousness
- ☐ Loss of balance

Gastrointestinal

- ☐ Heartburn
- ☐ Constipation
- ☐ Diarrhea
- ☐ Bloating/Gas
- ☐ Laxative use
- ☐ Bad Breath
- ☐ Nausea/vomiting
- ☐ Abdominal cramps/pain
- ☐ Rectal Pain
- ☐ Hemorrhoids
- ☐ Blood in stool

Respiratory

- ☐ Asthma
- ☐ Chronic Cough
- ☐ Shortness of breath
- ☐ Bronchitis
- ☐ Coughing Blood
- ☐ Pneumonia
- ☐ Pain w/breathing
- ☐ Mucous Production

Learning Disability

- ☐ ADHD
- ☐ Dyslexia
- ☐ Memory loss
- ☐ Autism spectrum

Neuropsychological

- ☐ Depression
- ☐ Disinterest
- ☐ Anxiety
- ☐ Schizophrenia
- ☐ Eating Disorder
- ☐ Concussion
- ☐ Fainting
- ☐ Dizziness
- ☐ Neuropathy
- ☐ Numbness
- ☐ Neurological condition (MS, ALS)

Ear/Nose/Throat/Eyes

- ☐ Vision loss/blurring/pain
- ☐ Hearing loss/ringing
- ☐ Sinus infections/problems
- ☐ Ear infections
- ☐ Nose Bleeds
- ☐ Problems with teeth
- ☐ Night Blindness
- ☐ Sores on lips, tongue or m
- ☐ Facial Pain
- ☐ Recurrent sore throat

Genitourinary

- ☐ Increased frequency
- ☐ Painful urination
- ☐ Blood in urine
- ☐ Discharge
- ☐ Kidney Stones
- ☐ Bladder/Yeast Infections
- ☐ Genital Sores
- ☐ Unable to hold urine
- ☐ Decrease in flow
- ☐ Urgency to void
- ☐ Wake at night to void

Cardiovascular

- ☐ Chest pain
- ☐ Stroke
- ☐ High blood pressure
- ☐ Low blood pressure
- ☐ Poor circulation
- ☐ Pacemaker
- ☐ Heart Attack
- ☐ Irregular Heartbeat
- ☐ Swelling hands/feet
- ☐ Varicose Veins
- ☐ Blood Clots
- ☐ Impotence

Adrenal

- ☐ Mental fog
- ☐ Poor focus
- ☐ Quick to react
- ☐ Low energy
- ☐ Fatigue
- ☐ Headache
- ☐ Chest tightness
- ☐ Restless legs
- ☐ Susceptible to stress

Doctor Section

- ☐ Vascular
- ☐ Metabolic
- ☐ Aneurism
- ☐ Neoplasm
- ☐ Infection
- ☐ Congenital
- ☐ Trauma

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LIFESTYLE

What is the biggest stressor in your life? ☐ Family ☐ Work ☐ Social ☐ Financial ☐ Health ☐ Time

What do you love to do in your spare time (hobbies)? ____

How often do you exercise? ☐ Daily ☐ 3-5 days/week ☐ 1-2 days/week ☐ Infrequently

Smoke? Y / N # Packs/week ________ Drink alcohol? Y / N # Drinks/week _______

Recreational Drug use: ______________________

Hours of sleep? ________ Feel rested? _________

Where is your current level of health? (circle) Very low Poor OK Good Excellent

If you had excellent health, what would you love to be able to do? ________________________________

FAMILY PROFILE

At Health*Tweak* we are here to help you and family live healthy and happy. Please mention below any health conditions or concerns they may have:

Children: ____

Spouse/Partner: ____

Other family members: ____

INFORMED CONSENT TO MASSAGE THERAPY TREATMENT

I understand that the Registered Massage Therapist is providing services within his or her scope of practice as defined by the College of Massage Therapists of Ontario. I hereby request and consent to the service of massage therapy treatment and other massage procedures, including various modes of remedial exercise and hydrotherapy.

I am informed that, as in all health care, in the practice of massage therapy there are some very slight risks to treatment, including, but not limited to, muscle tenderness, light-headedness, or dizziness.

I understand that the therapist is not a physician and does not diagnose illness or disease or any other physical or mental disorder. I clearly understand that massage therapy is not a substitute for medical examination.
I have completed my medical history form and have disclosed to the therapist all of those medical conditions affecting me. It is my responsibility to keep the massage therapist updated on my medical history.

I have read the above consent. I agree to this consent form to cover the entire course of the treatment for my present condition and for any future condition(s) for which I seek treatment. I understand that at any time I may withdraw my consent, and treatment will be stopped. I understand that failure to provide 24 hours notice prior to cancelling an appointment may result in a charge of a $40.00 missed appointment fee.

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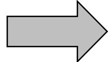
I understand that because of the nature of HealthTweak Wellness Group, patient files and information contained in files may be shared among practitioners for the mutual benefit of patient treatment. All information will remain confidential. I understand that written consent must be obtained for a practitioner to remove/transfer file information outside of HealthTweak Wellness Group.

PERSONAL HEALTH INFORMATION CONSENT FORM

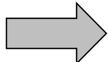
I understand that Health*Tweak* is my health information custodian. I consent to the collection, use and disclosure of my personal health information for treatment and other health care reasons. Health*Tweak* is a multidisciplinary clinic, and therefore treatment notes may be shared between practitioners to best treat the patient.

I understand that to provide me with Massage Therapy, Chiropractic, Physiotherapy, Naturopathic Medicine or any other health care services, Health*Tweak* will collect personal information about me (e.g. birth date, home contact information, health history, etc.)

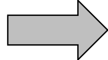
I understand that Health*Tweak* will only collect, use, or disclose my personal health information with my express or implied consent; unless a collection, use, or disclosure without consent is permitted or required by law.



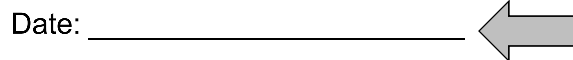
○ I give permission to HealthTweak to contact your primary healthcare provider such as my medical doctor, nurse practitioner ect.



Name: ______________________ Name of Witness: ________________________



Signature: ___________________ Date: _______________________



Thank you for completing this form.