Massage Therapy Health History Form

acacia INTEGRATIVE HEALTH CLINIC *Creating health together, through science and nature.*

Name_____ **Birthdate**_____ **MSP#**_____

Address_____**City**_____

Prov/State_____ **Postal Code**_____ **Phone (home)**_____

Phone (work) _____**Email** _____ **Best time to call** _____

Occupation_____ **(full/part time)**

Emergency Contact _____ **Relation?** _____ **Phone**_____

How did you hear about Acacia?_____

Please list below all other health professionals you are currently seeing (complimentary and conventional) and their contact numbers. Include their area of practice (GP, Chiropractor, etc…)

ICBC or WCB Claim: Yes 1 **No** 1
Date of Injury (if applicable): _____

Primary Concern_____

_____

_____

_____

How Long? _____

_____

When did it start?

_____

What makes the condition worse?

_____

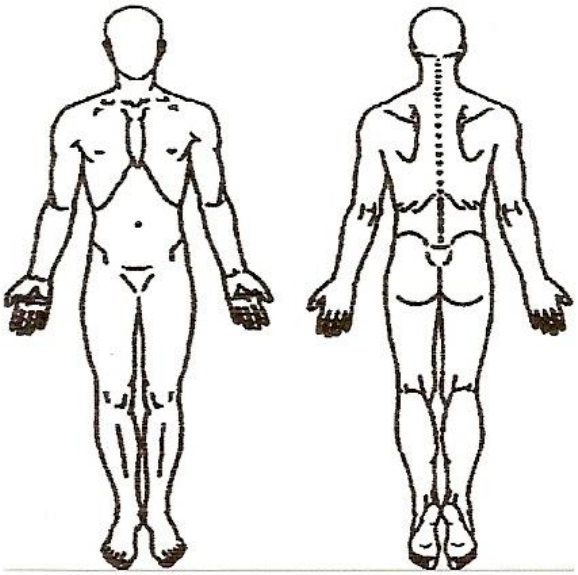
_____

What makes the condition better?

_____

_____

Please indicate on the diagram the nature of your symptoms, using the symbols indicated:



Aching	O O
Stabbing	X X X
Shooting	→ →
Burning	# # #
Numbness or Tingling	≈ ≈

Medications you are presently taking:

_____

Surgeries, major injuries or accidents you have had:

_____

Known Allergies:

_____

Please rate the following in your best opinion:

Stress level:	2 None	2 Slight	2 Moderate	2 Severe
Physical activity:	2 None	2 Low	2 Moderate	2 High
Diet:	2 Poor	2 Average	2 Good	2 Excellent
Sleep & Energy Levels:	2 Poor	2 Average	2 Good	2 Excellent

List any Activities, Sport, Hobbies
(ie. Jogging, Hockey, Curling, Computers, Weaving)

Please circle and place a C (current) or P (past) on any of the following conditions that apply to you:

Heart Condition	Circulatory Disorder	Menstrual Problems
Osteoporosis	Stroke (CVA)	High/Low Blood Pressure
TMJ Syndrome	Currently Pregnancy	Seizures
Fibromyalgia	Contagious Condition	Arthritis
Headaches/Migraines	Nausea	Loss of Sensation/Tingling
Tumors/Cysts	Dizziness/Vertigo	Spinal Injury
Fractures/Dislocations	Backaches	Varicose Veins
Bruises Easily	Cancer	Diabetes

Condition: _____

Skin Condition: _____

Digestive Condition: _____

Other _____

Acacia Integrated Health
101-391 Tyee Rd., Victoria, BC, V9O 0A9
Tel: 250.475.1522

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Confidentiality Agreement and Informed Consent to Treatment

For Massage Therapy Patients

Registered Massage Therapists are health care professionals committed to restoring and maintaining optimal health and pain-free function of the body.

They are educated and trained to accurately assess and treat with techniques that include massage and manual therapy, joint mobilization, hydrotherapy, and rehabilitative exercise such as stretching, strengthening, postural exercise and patient education.

I understand that I must inform my massage therapist immediately of any disease process that I may be suffering from, if I am on any medication or over the counter drugs, if I am pregnant or suspect I may be pregnant.

I understand that my identity will be protected at all times and, if necessary, identifying information will be altered to protect my privacy. I understand that a record will be kept of the health services provided to me. This record will be kept confidential and will not be released to others unless so directed by myself or unless law requires it. I understand that the massage therapists at this clinic are legally obligated to supersede confidentiality if they become aware of current child abuse or neglect, threats to harm or kill another individual and serious threat of suicide involved with my case. I understand that I may look at my medical record at anytime and can request a copy of it by paying the appropriate fee. I understand that information from my medical record may be analyzed for research purposes and that my identity will be protected and kept confidential.

I understand that fees are payable at the time of appointment.

I understand that <u>24 hours notice is required</u> for appointment cancellation; otherwise I will be responsible for the cancellation fee.

I understand that the results are not guaranteed. I do not expect the Massage Therapist(s) will be able to anticipate and explain all risks and complications. With this knowledge, I voluntarily consent to the therapeutic procedures mentioned above. I intend this consent form to cover the entire course of treatment with any/all Acacia Registered Massage Therapist(s). I understand that I am free to withdraw my consent and to discontinue participation in these procedures at any time.

_____ _____

Patient Name: (Please Print) Name of guardian if patient is a child

_____ _____

Signature of Patient (or Guardian) Today's Date

Optional Consent (please initial box)

☐ I hereby give my consent to share my file and/or my medical history and current treatment plan options with any other practitioner that I am currently seeing (or may be referred to in the future) at Acacia Integrative Health Clinic for the sole purpose of improving my current health condition and/or to discuss current and/or future treatment options.

Massage Therapist Signature: _____