acacia health
health, through science & nature

Health History Form:
Massage Therapy

Name _____ Birthdate _____

Address _____ City _____

Province _____ Postal Code _____

Phone (home/cell) _____ Phone (work) _____

Email _____ Occupation _____

Emergency Contact _____ Relation? _____

Emergency Contact Phone _____

How did you hear about Acacia? _____

Primary Concern: _____

_____

_____

When did it start?

_____

_____

How did it start?

_____

_____

What makes the condition worse?

_____

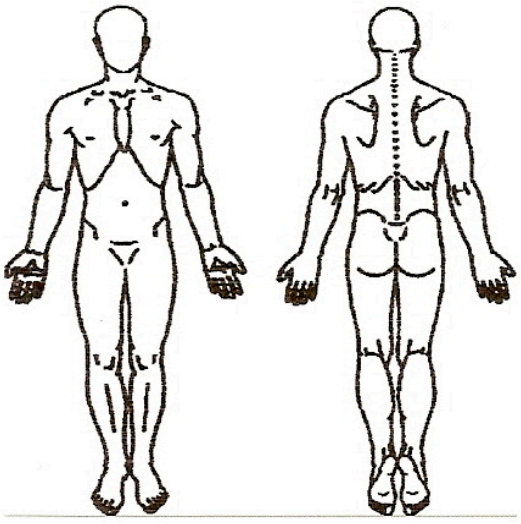
_____

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

List any Activities, Sport, Hobbies
(ie. Running, Hockey, Curling, Dancing, Pottery, Weaving, Kite Flying, Fish Whispering)

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	Varicose Veins
Fibromyalgia	Contagious Condition	Seizures
Headaches/Migraines	Nausea	Arthritis
Tumors/Cysts	Dizziness/Vertigo	Loss of Sensation/Tingling
Fractures/Dislocations	Backaches	Spinal Injury
Bruises Easily	Respiratory Condition: _____	
Cancer	Skin Condition: _____	
Diabetes	Digestive Condition: _____	
	Other: _____	

Privacy/Information Acknowledgement

I authorize the clinic and its associated health professionals to collect my personal and medical information as documented above. In addition, I authorize the clinic and its associated health professionals to communicate with my family doctor and/or referring doctor as deemed necessary for my beneficial treatment. I also understand that my personal and medical information is confidential and will only be disclosed to third parties with my permission.

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 any time 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 agree

Cancelation Policy

Your appointment time is reserved just for you. A late cancellation or missed visit leaves a hole in the therapists' day that could have been filled by another patient. As such, we require 24-hour notice for any cancellations or changes to your appointment. Patients who provide less than 24-hour notice, or miss their appointment, will be charged a cancellation fee, this cancelation fee can range from a portion up to the full cost of the appointment.

If I am sick or otherwise experiencing symptoms that impact my ability to receive this treatment and must cancel in short notice, the cancelation fee will likely be waived.

☐ I agree

Collaborative Health Agreement

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.

☐ I agree

Covid-19 Policy Agreement

I understand that in adherence to the requirements and guidelines set out by the College of Massage Therapists of BC on the date of any and all treatment(s) the massage therapist will require a pre-screen for COVID 19 a day before, upon arrival, and before treatment starts.

I understand it is my (the patients) responsibility to answer all prescreen questions truthfully and to the best of my knowledge. And to notify the clinic immediately if I or anyone I live with are presenting with symptoms before or up to 14 days following my treatment.

If I am presenting with any symptoms of COVID19 or do not meet the prescreen criteria, myself or the massage therapist must cancel the appointment immediately and I must follow the self-isolating guidelines as per the BCCDC before rebooking within the clinic. There will be no charge or financial penalty for COVID 19 related cancellations.

If I am presenting COVID 19 symptoms I understand and consent to the RMT sharing this information with their co-workers and clinic staff and that my personal information and name will remain confidential outside of the clinic. My profile will be updated for monitoring purposes.

I understand the RMT is following all required protocols set out by Work Safe, and the CMTBC, to reduce or mitigate risk, but that any massage treatment can carry some risk of COVID 19 transmission as the risk cannot be reduced to zero.

☐ I agree

Name: _____

Signature: _____

Date: _____