

christine genest r.m.t.

health history

This information on this form is used to plan an efficient massage therapy treatment that will best suit your needs, and goal. All information will be kept confidential and be used by the Registered Massage Therapist. Should your health status change, it is your responsibility to inform your therapist to update your form.

Name: _____ Signature: _____ Date: _____

Address: _____

Unit # _____ City _____ Province _____ Postal Code _____
Telephone: (Home) _____ Telephone: (Work) _____

Occupation: _____ Age: _____ Date of Birth: _____

Where did you hear about this clinic? : _____

Chief Complaint: _____

Doctor: _____ Address: _____

Height: _____ Weight: _____ Pulse: _____ Blood Pressure: _____

1. Please check all that

	Current	Previous		Current	Previous		Current	Previous
Head/Neck			Other Conditions			Muscles / Joints /		
Headache	<input type="checkbox"/>	<input type="checkbox"/>	Difficulty digestion	<input type="checkbox"/>	<input type="checkbox"/>	Soft Tissue Pain/ Stiffness		
Type: _____			Heart burns/ ulcers	<input type="checkbox"/>	<input type="checkbox"/>	Neck	<input type="checkbox"/>	<input type="checkbox"/>
Vision problems	<input type="checkbox"/>	<input type="checkbox"/>	Constipation	<input type="checkbox"/>	<input type="checkbox"/>	Shoulder: R / L	<input type="checkbox"/>	<input type="checkbox"/>
Earaches	<input type="checkbox"/>	<input type="checkbox"/>	Liver	<input type="checkbox"/>	<input type="checkbox"/>	Elbow: R / L	<input type="checkbox"/>	<input type="checkbox"/>
Respiratory			Gall bladder	<input type="checkbox"/>	<input type="checkbox"/>	Wrist: R / L	<input type="checkbox"/>	<input type="checkbox"/>
Chronic cough	<input type="checkbox"/>	<input type="checkbox"/>	Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	Upper back	<input type="checkbox"/>	<input type="checkbox"/>
Shortness of breath	<input type="checkbox"/>	<input type="checkbox"/>	Onset: _____			Mid back	<input type="checkbox"/>	<input type="checkbox"/>
Asthma	<input type="checkbox"/>	<input type="checkbox"/>	Hypoglycemia	<input type="checkbox"/>	<input type="checkbox"/>	Low back	<input type="checkbox"/>	<input type="checkbox"/>
Bronchitis	<input type="checkbox"/>	<input type="checkbox"/>	Osteoporosis	<input type="checkbox"/>	<input type="checkbox"/>	Leg: R / L	<input type="checkbox"/>	<input type="checkbox"/>
Emphysema	<input type="checkbox"/>	<input type="checkbox"/>	Sinus	<input type="checkbox"/>	<input type="checkbox"/>	Knee: R / L	<input type="checkbox"/>	<input type="checkbox"/>
Cardiovascular			Cancer	<input type="checkbox"/>	<input type="checkbox"/>	Ankle: R / L	<input type="checkbox"/>	<input type="checkbox"/>
High blood pressure	<input type="checkbox"/>	<input type="checkbox"/>	Insomnia	<input type="checkbox"/>	<input type="checkbox"/>	Other	<input type="checkbox"/>	<input type="checkbox"/>
Low blood pressure	<input type="checkbox"/>	<input type="checkbox"/>	Arthritis	<input type="checkbox"/>	<input type="checkbox"/>	Lifestyle Actions		
Heart disease	<input type="checkbox"/>	<input type="checkbox"/>	Fribromyalgia	<input type="checkbox"/>	<input type="checkbox"/>	Smoking	<input type="checkbox"/>	<input type="checkbox"/>
Atherosclerosis	<input type="checkbox"/>	<input type="checkbox"/>	Hernia	<input type="checkbox"/>	<input type="checkbox"/>	Alcohol use		
Phlebitis	<input type="checkbox"/>	<input type="checkbox"/>	Type: _____			Daily	<input type="checkbox"/>	<input type="checkbox"/>
Stroke	<input type="checkbox"/>	<input type="checkbox"/>	Urinary disorders	<input type="checkbox"/>	<input type="checkbox"/>	Social	<input type="checkbox"/>	<input type="checkbox"/>
Varicose veins	<input type="checkbox"/>	<input type="checkbox"/>	Epilepsy	<input type="checkbox"/>	<input type="checkbox"/>	Exercise		
Congestive heart failure	<input type="checkbox"/>	<input type="checkbox"/>	Hemophilia	<input type="checkbox"/>	<input type="checkbox"/>	Regular exercise	<input type="checkbox"/>	<input type="checkbox"/>
Pacemaker	<input type="checkbox"/>	<input type="checkbox"/>	Loss of sensation	<input type="checkbox"/>	<input type="checkbox"/>	Frequency : _____		
Myocardial infarctus	<input type="checkbox"/>	<input type="checkbox"/>	Hypersensitivity	<input type="checkbox"/>	<input type="checkbox"/>	Coffee /tea/caffeinated drinks		
Infections			Skin			1-3/day	<input type="checkbox"/>	<input type="checkbox"/>
Herpes	<input type="checkbox"/>	<input type="checkbox"/>	Skin conditions	<input type="checkbox"/>	<input type="checkbox"/>	3+/day	<input type="checkbox"/>	<input type="checkbox"/>
Hepatitis	<input type="checkbox"/>	<input type="checkbox"/>	Type: _____			Relaxation / Meditation	<input type="checkbox"/>	<input type="checkbox"/>
Plantar warts	<input type="checkbox"/>	<input type="checkbox"/>	Bruise easily	<input type="checkbox"/>	<input type="checkbox"/>	Type: _____		
Tuberculosis	<input type="checkbox"/>	<input type="checkbox"/>	Women			Other Heath Care		
HIV, AIDS	<input type="checkbox"/>	<input type="checkbox"/>	Menstrual problems	<input type="checkbox"/>	<input type="checkbox"/>	Chiropractic	<input type="checkbox"/>	<input type="checkbox"/>
STD	<input type="checkbox"/>	<input type="checkbox"/>	Cesarean section	<input type="checkbox"/>	<input type="checkbox"/>	Physiotherapy	<input type="checkbox"/>	<input type="checkbox"/>
Allergies			Pregnancy	<input type="checkbox"/>	<input type="checkbox"/>	Medic Alert Chain/ bracelet	Yes	No
Nuts	<input type="checkbox"/>	<input type="checkbox"/>	Due date (D/M/Y) _____			Other Medical Conditions		
Food	<input type="checkbox"/>	<input type="checkbox"/>	Children: numbers _____			_____		
Drug	<input type="checkbox"/>	<input type="checkbox"/>	Menopausal	<input type="checkbox"/>	<input type="checkbox"/>	_____		
Latex/Silicone	<input type="checkbox"/>	<input type="checkbox"/>				_____		
Others: _____								

Please turn page over

Current medication (name and for what condition):

2. Family Health History: some health conditions are hereditary and run in families. Please list any illnesses /conditions that have affected family members: - Indicate relationship:

3. Special notations - check all that apply:

- Pins, wires, plates, artificial joints or limbs.

If present, location: _____

- Special equipment: wheelchair, walker, crutches, cane
- Dentures. Glasses, contact lenses. Hearing aids

4. Surgery: list surgeries (past and booked) with type and date:

5. Injury (including motor vehicle accident): please list type, date and current symptoms:

6. Case history - information updates

Date: _____

Signature: _____

Date: _____

Signature: _____

Date: _____

Signature: _____

Date: _____

Signature: _____

Date: _____

Signature: _____

Date: _____

Signature: _____

Date: _____

Signature: _____

Date: _____

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Signature: _____

Date: _____

Signature: _____

Date: _____

Signature: _____

Office Policies for Christine Genest, R.M.T.

I know that your time is important to you, therefore I try my very best to stay on schedule and respect your time. Once your appointment is booked, it is held for you.

If you are running late, the remainder of the treatment time will be given at full treatment fee. If I am running late, you will receive your full treatment time.

CLIENT INITIAL: _____

In the event that your appointment needs to be cancelled or rescheduled, please notify me directly at least 24 hours in advanced. Missed or appointments that are cancelled within 24 hours will be billed for the full treatment fee.

I am aware that there are events that may come up at the last minute, therefore family emergencies, illnesses, accidents and such events will be considered.

One missed appointment will be allowed at no charge to you.

NOTE: Missed appointments are not covered by your extended health care.

CLIENT INITIAL: _____

A period of 15 minutes is given before a call is made regarding your appointment. If I am unable to reach you, the treatment time may be given to another client, and you will be responsible for your missed appointment. Please make sure that I have the appropriate numbers to reach you.

CLIENT INITIAL: _____

Should you require a reminder call, please let me know and I will be happy to do so.

Payment is required in full at the end of each treatment. Methods of payment include cash, Debit, Mastercard or Visa. Personal cheques are not accepted.

If you have any questions regarding the policies, please feel free to ask me.

Thank you,
Christine Genest, R.M.T.

CLIENT SIGNATURE: _____

Date: _____