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:_____ Date of Birth: _____Age: _____

Where did you hear about this clinic? : _____

Chief Complaint: _____

Doctor: _____ Telephone: (Office): _____

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

Please check all that

	Current	Previous
Head/Neck		
Headache	☐	☐
Type: _____		
Vision problems	☐	☐
Earaches	☐	☐
Respiratory		
Chronic cough	☐	☐
Shortness of breath	☐	☐
Asthma	☐	☐
Bronchitis	☐	☐
Emphysema	☐	☐
Cardiovascular		
High blood pressure	☐	☐
Low blood pressure	☐	☐
Heart disease	☐	☐
Atherosclerosis	☐	☐
Phlebitis	☐	☐
Stroke	☐	☐
Varicose veins	☐	☐
Congestive heart failure	☐	☐
Pacemaker	☐	☐
Myocardial infarctus	☐	☐
Infections		
Herpes	☐	☐
Hepatitis	☐	☐
Plantar warts	☐	☐
Tuberculosis	☐	☐
HIV, AIDS	☐	☐
STD	☐	☐
Allergies		
Nuts	☐	☐
Food	☐	☐
Drug	☐	☐
Latex	☐	☐
Others: _____		

	Current	Previous
Other Conditions		
Difficulty digestion	☐	☐
Heart burns/ ulcers	☐	☐
Constipation	☐	☐
Liver	☐	☐
Gall bladder	☐	☐
Diabetes	☐	☐
Onset: _____		
Hypoglycemia	☐	☐
Osteoporosis	☐	☐
Sinus	☐	☐
Cancer	☐	☐
Insomnia	☐	☐
Arthritis	☐	☐
Fribromyalgia	☐	☐
Hernia	☐	☐
Type: _____		
Urinary disorders	☐	☐
Epilepsy	☐	☐
Hemophilia	☐	☐
Loss of sensation	☐	☐
Hypersensitivity	☐	☐
Skin		
Skin conditions	☐	☐
Type: _____		
Bruise easily	☐	☐
Women		
Menstrual problems	☐	☐
Cesarean section	☐	☐
Pregnancy	☐	☐
Due date (D/M/Y) _____		
Children: numbers _____		
Menopausal	☐	☐

	Current	Previous
Muscles / Joints / Soft Tissue Pain/ Stiffness		
Neck	☐	☐
Shoulder: R / L	☐	☐
Elbow: R / L	☐	☐
Wrist: R / L	☐	☐
Upper back	☐	☐
Mid back	☐	☐
Low back	☐	☐
Leg: R / L	☐	☐
Knee: R / L	☐	☐
Ankle: R / L	☐	☐
Other	☐	☐
Lifestyle Actions		
Smoking	☐	☐
Alcohol use		
Daily	☐	☐
Social	☐	☐
Exercise		
Regular exercise	☐	☐
Frequency : _____		
Coffee /tea/caffeinated drinks		
1-3/day	☐	☐
3+/day	☐	☐
Relaxation / Meditation	☐	☐
Type: _____		
Other Heath Care		
Chiropractic	☐	☐
Physiotherapy	☐	☐
Medic Alert Chain/ bracelet	*Yes* ☐	*No* ☐
Other Medical Conditions		

_____

_____

_____

Please turn page over

1. 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: _____

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: _____

Missed appointments will be billed for the full treatment fee. One missed appointment will be allowed at no charge to you.
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.

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

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

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

CLIENT SIGNATURE: _____

Date: _____