Ruah Massage Therapy Clinic
128 Annette Street, Toronto, ON
647.209.6599
gcs35@rogers.com

-Health History Form-

Name: _____ Home Tel: _____

Address: _____ Apt. #: _____ 2nd Tel: _____ Cell ☐ Work ☐ ext: _____

City: _____ Postal Code: _____ Date of Birth (dd/mm/yr): ____/____/____

Occupation: _____ Is this your first massage therapy session? Yes / No

Email: _____

Referred by: Yellow Pages ☐ or Other ☐ if so then how/whom? _____

What is your Primary Concern or what is/are you Massage Therapy goal(s): _____

_____

Primary Health Care Physician or Doctor: Name: _____ M.D. ☐ D.C. ☐ N.D. ☐ Other: _____

Address: _____ City: _____ Tel: _____

Please carefully read the following and sign below. If you have any questions or concerns, please do not hesitate to ask.

I understand that the information that I give on this form will be confidential and will be used for no purpose other than the professional therapist's clinical records.

I acknowledge that the therapist has provided me with such information as is pertinent to treatment for the above listed concerns.

I understand that I may stop the treatment at any time before or during the treatment process.

Cancellation of appointment: We require 24 business hours notice of appointment cancellation. Failure to do so will result in the treatment fee being charged. All fees are donated to non-profit organizations such as the Make-a-Wish Foundation or the Red Cross.

I, _____, of my own free will consent to be treated for the above stated areas of concern.

Signed: _____ Date: _____

Please turn form over

Health History: Please indicate with an **X** which of the following you are currently experiencing or have previously experienced.

Muscle & Joint Concerns

- ☐ Neck
- ☐ Shoulder
- ☐ Upper Back
- ☐ Mid Back
- ☐ Low Back
- ☐ Arms
- ☐ Legs
- ☐ Knees
- ☐ Hips

Other: _____

Head

- ☐ Tension headaches
- ☐ Migraines
- ☐ Tooth/jaw/ear pain
- ☐ Head trauma

Other: _____

Respiratory

- ☐ Chronic cough
- ☐ Shortness of Breath
- ☐ Bronchitis
- ☐ Asthma
- ☐ Emphysema
- ☐ Pneumonia
- ☐ Sinus problems

Cardiovascular

- ☐ High Blood Pressure
- ☐ Low Blood Pressure
- ☐ Heart Attack
- ☐ Phlebitis
- ☐ Stroke/CVA
- ☐ Pacemaker
- ☐ Heart disease
- ☐ Angina
- ☐ Chronic Congestive Heart Failure

Infectious Disease

- ☐ Hepatitis
- ☐ Tuberculosis
- ☐ HIV

Other: _____

Skin

- ☐ Skin Condition

Specify: _____

- ☐ Bruise easily
- ☐ Herpes
- ☐ Varicose veins
- ☐ Athletes foot
- ☐ Loss of Sensation

Areas: _____

Other Concerns

- ☐ Neurological conditions
- ☐ Epilepsy
- ☐ Diabetes

Type: _____

Onset: _____

- ☐ Allergies
- ☐ Anaphylaxis
- ☐ Cancer
- ☐ Arthritis

Type: _____

Areas: _____

Perinatal

- ☐ Pregnant

Due Date:

How many children: _____

Please list Current Medications:

-
-
-
-
-

What is your general health status:_____

Please list any accidents, injuries, falls and/or breaks:	**Please list any surgeries:**
• Date:	• Date:
• Date:	• Date:
• Date:	• Date:
• Date:	• Date:

Please list any pins, wires, staples, plates and/or prosthetics:

•

Other Medical Conditions or comments: