Kiera Squire, RMT

Health History

An accurate health history is important to ensure that it is safe for you to receive a massage treatment. Feel free to ask any questions about the information being requested. If your health changes in the future, please let us know. All information gathered for this treatment is confidential unless allowed or requested by law. You will be asked to provide written authorization for release of any information

Name: _____ Phone #: _____
Address: _____
Occupation: _____ Date of Birth: _____
Email: _____
Have you received massage therapy before? Yes _____ No _____
Did a health care practitioner refer you for massage therapy? Yes _____ No _____

Please indicate conditions you are experiencing or have experienced (past 10 years)

Muscle/Joint Discomfort
___ Headaches
___ Head Trauma/concussion
___ Neck pain/injury
___ Whiplash
___ Back pain/weakness
___ Shoulder pain/injury
___ Arm Pain/weakness
___ Sciatic/hip pain
___ Leg pain/weakness
___ Knee pain/injury
___ Foot pain/injury

Respiratory
___ Asthma/Bronchitis
___ Chronic cough
___ Pneumonia
___ Shortness of breath
___ Allergies/sinus problems
___ Emphysema

Contagious
___ HIV/AIDS
___ Hepatitis A/B/C
___ Tuberculosis
___ Skin Condition
___ Other: _____

Skin
___ Rash/hives
___ Sensitive
___ Cold Sores
___ Bruise easily

Cardiovascular
___ High/low blood pressure
___ Heart attack/stroke
___ Heart disease
___ Phlebitis/varicose veins
___ Rapid/slow heart beat
___ Hardening of arteries
___ Swelling of ankles
___ Chest pain/angina
___ Cold hands/feet

Eyes/Ears/Throat
___ Dizziness
___ Pain behind eyes
___ Blurred vision
___ Ringing in ears
___ Hearing loss
___ Recent dental work
___ TMJ/jaw cracking
___ Clenching/grinding teeth

Gastrointestinal
___ Nausea/vomiting
___ Constipation/diarrhea
___ Ulcers
___ Hiatus Hernia
___ Irritable Bowel Syndrome
___ Crohns/Colitis
___ Diverticulitis
___ Hypoglycemia
___ Gallbladder

Lifestyle
Exercise ___ Reg. ___ Seldom
Sleep ___ Reg. ___ Seldom
___ High work/family stress

Gynaecological (Women)
___ Currently Pregnant
___ PMS
___ Menopause
___ Other: _____

Other Conditions
___ Poor healing/bruising
___ Diabetes
___ Anemia
___ Fatigue
___ Loss of sensation
___ Epilepsy
___ Arthritis
___ Cancer
___ Multiple sclerosis
___ Fibromyalgia
___ Depression
___ Tendonitis/bursitis
___ Osteoporosis
___ Fractures/dislocations
___ Stiff/swollen joints
___ Degenerative Discs
___ Scoliosis
___ Thyroid

Genito-urinary
___ Painful/frequent urination
___ Kidney/gall stones
___ Kidney/bladder infection
___ Incontinence

Anything further you feel is important:_____

Kiera Squire, RMT

Health History

Current Medications/Supplements/Herbs:

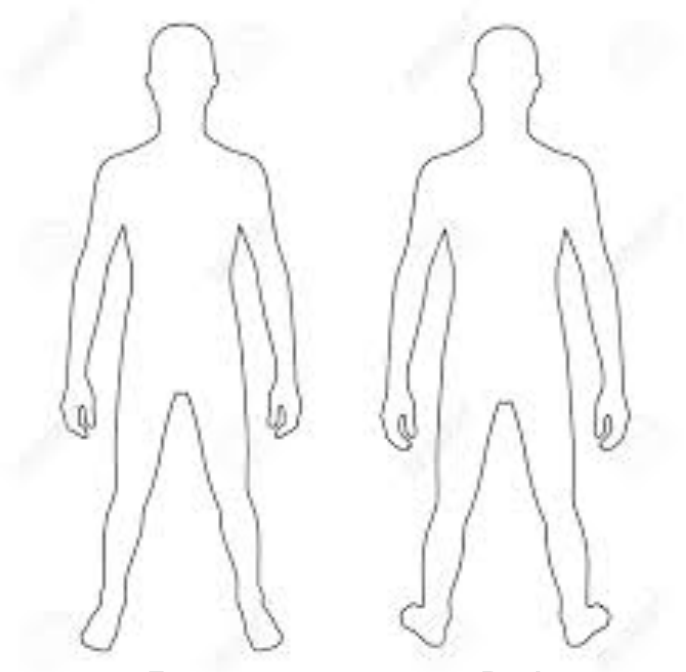
Medication:	Treatment:
_____	_____
_____	_____
_____	_____

Previous Injuries/surgeries

Injuries/surgeries	Date:
_____	_____
_____	_____
_____	_____

Allergies: _____

Please circle areas that require treatment



Front **Back**

I have read and understood the information in this consent and have had the opportunity to ask questions. I verify that all the information provided is accurate and complete and I consent to treatment.

Signature _____ **Date** _____

Update 1 _____ **Date** _____
Update 2 _____ **Date** _____
Update 3 _____ **Date** _____
Update 4 _____ **Date** _____
Update 5 _____ **Date** _____

Consent for Assessment and Treatment of Sensitive Areas

I, _____(name), have requested assessment and/or treatment by this Registered Massage Therapist (RMT) _____ (name) for treatment of the clinically relevant areas indicated below (please initial):

_____ Buttock (gluteal muscles)
_____ Chest Wall Muscles
_____ Upper Inner Thigh(s)
_____ Breast(s)

The RMT has explained the following to me and I fully understand the proposed assessment and/or treatment:

* The nature of the assessment, including the clinical reason(s) for assessment of the above area(s) are the draping methods to be used
* The expected benefits of the assessment
* The potential risks of the assessment
* The potential side effects of the assessment
* That consent is voluntary
* That I can withdraw or alter my consent at any time.

I voluntarily give my informed consent for the assessment and/or treatment as discussed and outlined above.

Client Name (print): _____
Client Signature: _____ Date: _____

Ongoing Treatment:

I am aware that the treatment of the above indicated area(s) is part of a treatment plan which has been discussed with me by my RMT. I confirm that, on the following date(s), the RMT has reviewed the treatment plan and I provide my informed consent.

Client Signature: _____ ***Date:*** _____
Client Signature: _____ ***Date:*** _____
Client Signature: _____ ***Date:*** _____
Client Signature: _____ ***Date:*** _____
Client Signature: _____ ***Date:*** _____