A Pathway to Wellness Health History Form

Please fill out this form. All information on this form will remain confidential once submitted to A Pathway To Wellness.

Name ____ Cell Phone ___________________

Email :_______________________________Best Time to Call? Not before_______ Not After___________

Address ____
Street/with lot number Town Postal Code

Type of work ________________________Company ___________________Work Phone:_______________

Date of Birth _____________ Weight ______ Height ____ Home Phone:___________________________

What motivated you to see us? _________________________________

Has this happened before? Y N If yes, when? ____________________________________

How did you discover the clinic/site? (Please be specific) _______________________________
Friend (who?) paper, health fair, sign, surfing internet, doctor, Facebook(group), 411, RMT find, google map

Are you available during the day for treatments? Y N
What days & time? _______________________________________

Do you require a receipt for extended care benefits? Y N or income tax? Y N

Amount of coverage $ ________ Insurer ______________________(Sunlife, Manulife, Greenshield, etc.)

Please complete the following health history ,This document will help in evaluating your condition and inform us of any necessary precautions which may be needed to ensure the best possible treatment for you as required by the Ontario Government.

Health History: Please mark the conditions that you currently (C) or previously (P) have experienced.

Muscle or joint pain

______Jaw locks, clicks or pops TMJ
______Neck
______Mid back
______Low back
______Hip L R
______Shoulder L R
______Elbow L R
______Wrist L R
______Hand L R
______Leg L R
______Knee L R
______Ankle L R
______Foot L R
______ Other: _______
______Scoliosis

Symptoms

____ Numbness Where? ________________
____ Burning Where? _________________
____ Sharp Pain Where? _________________
____ Dull Ache Where? _________________
____ Swelling Where? _________________
____ Stiffness Where? _________________

Sleeping Position

_____ Back______ Side R L
_____ Stomach
Do you experience insomnia? Y N
Do You Drink Tea / Coffee? Y N
How much per days ____ Cups

Cardiovascular

______ High/Low Blood Pressure
______ Heart Attack when?_______
______ Heart Disease
______ Phlebitis
______ Stroke/CVA When? _______
______ Pacemaker or other device
______ Poor Circulation
______ Varicose Veins
______Bruise Easily
______ Other

Respiratory

______Chronic Cough
______ Shortness of Breath
______Bronchitis
______Asthma
______Anxiety attacks
______ Emphysema ____smoking
______ Any Family Pathologies ______________
______ Sinus Problems

Infections

______ Hepatitis
______ TB
______ HIV / AIDS
______ Herpes
______ Plantar Warts

Women

_____ Pregnant? Due Date ____________
_____ Menstrual Pain
_____ Number of Children – Ages ______
_____Cesarean/Gynecological Surgery
_____Menopausal Symptoms

Other

____ Skin Sensitivities
Type ____________
____ Loss of Sensation
Where____________
____ Diabetes Type_____
Onset? ___________
____ Allergies
____ Epilepsy:type______
____ Cancer: Where _____
____Arthritis: Type _____
____ **Allergy to Coconuts**
____ Kidney/Bladder
____ Live/Gall Bladder
____ Fibromyalgia
____ Thyroid: Hyper
____ Constipation
____ Irritable Bowel Syndrome

Other Health Care past or presently

____ Reflexology Who?
____ Acupuncture
____ Massage Therapy
____ Physio Therapy
____ Chiropractor
____ Aromatherapy
____ Naturopath
____ Osteopath
____ Orthotics

Do You Use: ____Heat
____Cold
____Hot Baths

Strains/Pulled Muscles Ie. Groin, back
Where/When ______________________________
Where/When ______________________________

Other Injuries
Where/When __________________________________
Where/When __________________________________

Turn Over

Motor Vehicle Accidents
Car, Motor Bike, Snowmobile etc
_____ Rear Ended When? _____________
_____ T-Boned When? _____________
_____ Head On When? _____________
_____ Other When? _____________

Dislocations
When/Where? ____________________________
When/Where? ____________________________
Major Falls: I.e. thrown from horse, fell off roof
When/Where? ______________________
When/Where? ______________________

Head/Neck
_____ Vision Problems
_____ Vision Loss
_____ Ear Problems
_____ Hearing Loss
_____Contacts?
_____ Whiplash When? ______________
_____ Headaches
How often do you get headaches? ______________________
Where do you feel the headache pain?___________________
Do you know what causes the headaches? _______________
Do you have one now today? Y N

Surgery: Type/When ___________________________________
Type/When ___________________________________
Type/When ___________________________________

Type/When ___________________________________
Type/When __________________________________
Type/When ___________________________________

How would you define your stress level? ______________________________
Do you experience muscle cramping? N Y Where? ___________________

How many glasses of water per day? ___________

Doctor's Name: ______________________________________ City located in: ___________________ Phone number: ___________________

Medications:
Type: _______________________________________ For what condition ____________________________
Type: _______________________________________ For what condition ____________________________
Type: _______________________________________ For what condition ____________________________
Do you take Tylenol/Aspirin? Y N How often? ___________________

Other Supplements, I.e. Vitamins, Herbs, etc. (what ones) ____

Supplements are for? ____

Other: Do you have any other conditions which your practitioner should be aware of? I.e. Pins, Wires, joint replacements etc.

Yes No…I give A Pathway To Wellness to email me concerning appointments, occasional health information that may help me and clinic updates.

As a client of massage therapy you have the right to ask any questions pertaining to your assessment, treatment or use of heat.
You have the right to discontinue treatment at any time. As a client you acknowledge that **24 hours is required for an appointment change to avoid a full cost missed appointment fee. I am aware that a $25.00 charge is applied to NSF cheques, administrations work.**

Signature ____ DATE_______________________________________
If you have any concerns regarding our privacy policy please feel free to ask to read it, look on line, or you can also view it by clicking here

Consent for Sensitive Areas of Treatment: According to the Position Statement issued by the College of Massage Therapist of Ontario, there are four (4) areas of the body that require specific consent for treatment. Please read the following and check the appropriate box indicating the area to be treated in current and future treatments. **I ___________________________________,** give permission to my therapist to provide treatment to the following areas during our current and on-going future treatments.

☐ Inner Thigh ☐ Gluteal Tissue ☐ Abdomen ☐ Breast/Chest Wall(under arm, along the side of body)
I understand that I have the right to stop or modify the treatment at any time according to the Standards of Practice and the Code of Ethics.

Signature: ____ Date: ____

Do you need me to talk to one of your other Health Care Providers? Please provide signed consent for me to discuss your Health as related to massage.

Signature: ____ Date: _________________________________
If you require us to speak with your doctor, physiotherapist or anyone else, please place their name below.

I give ____ and _______________________________________permission to discuss my health care With each other as it pertains to each of their individual treatments if necessary. I understand that this will benefit me as they are complementary therapies. All discussions are kept confidential between them.

Consent for Acupuncture Treatment

For acupuncture, I am aware that bruising may result from treatment; applying ice can help reduce and increase healing time if bruising occurs. Any discomfort or concerns should be discussed at any time during a treatment.

Signature: ____ DATE_______________________________________