



42Wellness
#210-1560 Yonge Street
Toronto ON M4T 2S9
Tel: 416-887-1400
Email: info@42wellness.com

Health History Form

(Please print and complete the form in full)

For your information: an accurate health history is important to ensure that it is safe for you to receive a massage treatment. If your health status changes in the future, please let me know. All information gathered for this treatment is confidential except as required or allowed by law or except to facilitate diagnosis (assessment) or treatment. You will be asked to provide written authorization for release of any information.

Name: _____ Tel: (C) _____

Address: _____ Email: _____

Postal Code: _____

Occupation: _____ Date of Birth: _____ Age: _____

Referred by: _____ Reason for visit: _____

Health History: Please indicate conditions you are experiencing, or that have been significant in the past

RESPIRATORY	OTHER CONDITIONS	WOMEN
<input type="checkbox"/> Chronic Cough <input type="checkbox"/> Shortness of breath <input type="checkbox"/> Bronchitis <input type="checkbox"/> Asthma <input type="checkbox"/> Emphysema	<input type="checkbox"/> Loss of sensation Area _____ <input type="checkbox"/> Diabetes (Onset _____) <input type="checkbox"/> Allergies Type _____ <input type="checkbox"/> Epilepsy <input type="checkbox"/> Cancer Onset/Type _____ <input type="checkbox"/> Arthritis	<input type="checkbox"/> Pregnant Due _____ <input type="checkbox"/> Menstrual Discomfort _____
CARDIOVASCULAR <input type="checkbox"/> High blood pressure <input type="checkbox"/> Low blood pressure <input type="checkbox"/> Chronic congestive heart failure <input type="checkbox"/> Heart attack <input type="checkbox"/> History of myocardial infarction <input type="checkbox"/> Stroke/cerebro vascular accident <input type="checkbox"/> Pacemaker or like device	HEAD/NECK <input type="checkbox"/> Vision Problems <input type="checkbox"/> Vision Loss <input type="checkbox"/> Ear Problems <input type="checkbox"/> Hearing Loss	SOFT TISSUE/JOINT DISCOMFORT AREA AND ITS NATURE <input type="checkbox"/> Neck _____ <input type="checkbox"/> Back _____ <input type="checkbox"/> Shoulders _____ <input type="checkbox"/> Hips _____ <input type="checkbox"/> Knees _____ <input type="checkbox"/> Other _____
SKIN <input type="checkbox"/> Skin conditions Specify _____	INFECTIONS <input type="checkbox"/> Hepatitis <input type="checkbox"/> TB <input type="checkbox"/> HIV	

Current Medications: 1 _____ 2 _____ Condition it treats: 1 _____ 2 _____	Personal Physician: _____ Last visit date: _____ Surgery Type: _____ Date: _____
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Significant injuries: _____ Date/Type: _____

Other Medical Conditions (e.g. Digestive, Gynecological, Hemophilia, etc.): _____

Of Special Note – Presence of internal pins, wires, plates, etc: _____

Signature _____ Date _____



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INFORMED CONSENT FORM

Massage Therapy is the manipulation of the soft tissues of the body for a therapeutic effect on the muscular, nervous and circulatory systems. Massage helps to prevent and reduce stress and tension. As well as the discomfort of injuries or chronic conditions.

Your therapist will be working with you by means of massage treatments, as well as designing a home remedial exercise program, if necessary. To start, you will be asked to fill out a general health questionnaire. All information in this form is confidential. Then, a brief physical evaluation of your problem may be conducted prior to the massage. Afterwards, a treatment plan, in keeping with your desired health goals, will be discussed with you. Any other alternatives to massage will also be suggested at that time or after the massage.

You are encouraged to ask any questions you may have regarding your treatment. Should you have any concerns or feel uncomfortable at any time during your treatment, you should feel free to inform your therapist. Positive feedback is, of course, also appreciated. During treatment, you are covered by linen at all times, with only the body part being treated exposed. Common treatment areas include legs, back, neck, face, scalp and arms. It is quite acceptable to request that a certain area not be treated.

Benefits of massage:

- Relief of pain
- Decreased muscular tension
- General relaxation
- Increased circulation
- Increased joint mobility
- Increased body awareness

Please note: After a therapeutic massage, you may experience some discomfort (similar to that encountered when starting a new exercise program) as your body adjusts to the releasing of the soft tissues. This reaction is temporary and, in most cases, will not occur. Your therapist will give you instructions to minimize this reaction.

Insurance coverage: While OHIP does not cover massage therapy. Many extended health care plans provide full or partial coverage. You are responsible for the full treatment fee and for obtaining reimbursement from your insurance company.

Cancellation Policy: If unable to keep your appointment, please give no less than 24 hours' notice or the full fee will be charged.

I have read and understood all of the above information:

Signed: _____

Dated: _____