HEALTH HISTORY FORM – Charlene O'Grady, B.A., R.M.T., 306 - 55 Erb St. E., Waterloo, ON

Ph: 519-569-9455 Email: RMTogrady@gmail.com

The information requested below will assist me in treating you safely. Feel free to ask any questions about the information being requested. Please note that all information provided below will be kept confidential unless allowed or required by law. Your written permission will be required to release any information			
Name:		Date of Birth:	
Address:			
City:		Province:	Postal Code:
Home Phone:	Work Phone:	Cell Phone:	
Email:		Preferred Method of Contact:	
Occupation:			
Have you received massage therapy before? ☐ Yes ☐ No			
Did a health care practitioner refer you for massage therapy? ☐ Yes ☐ No			
If yes, please provide Name:		Phone:	
Family physician:	Address:	Phone:	
Have you received treatment from another health care professional in the past year? ☐ Yes ☐ No			
If yes, please provide type of treatment (chiropractic, physiotherapy, etc):			
Emergency Contact:		Relationship:	Phone:
Do you have extended health care benefits? ☐ Yes ☐ No If yes, company name:			
Please list all current medications and conditions they are treating:			
Accidents/Injuries:		Date of occurrence:	
Were these injuries sustained as a result of a motor vehicle accident? ☐ Yes ☐ No			
Were these injuries sustained at work? ☐ Yes ☐ No			
Please list all surgeries and dates:			
Primary Complaint:			

Please indicate conditions you are experiencing or have experienced. Please indicate dates.

Cardiovascular:
☐ High Blood Pressure
☐ Low Blood Pressure
☐ Chronic Congestive Heart Failure
☐ Heart Attack
☐ Heart Disease
☐ Heart Palpitations
☐ Heart Murmur
☐ Stroke / CVA
☐ Aneurism
☐ Angina
☐ Blood Clots
☐ Raynaud's Disease
☐ Phlebitis / Varicose Veins
☐ Poor Circulation
☐ Pacemaker or Similar Device

Respiratory:
☐ Chronic Cough
☐ Shortness of Breath
☐ Bronchitis
☐ Asthma
☐ Emphysema
☐ Pneumonia
☐ Tuberculosis
☐ Sinusitis
☐ Sinus Congestion
Do you smoke? ☐ Yes ☐ No

Blood:
☐ Anaemia
☐ Haemophilia
☐ Leukemia
☐ Hepatitis A B C

Lifestyle:
Regular Exercise
☐ Yes ☐ Mostly ☐ No
Drink Plenty of Water
☐ Yes ☐ Mostly ☐ No
8 Hours of Sleep Nightly
☐ Yes ☐ Mostly ☐ No
Good Eating Habits
☐ Yes ☐ Mostly ☐ No

Gastrointestinal:
☐ Constipation
☐ Diarrhea
☐ Gas / Bloating
☐ Nausea / Vomiting
☐ Irritable Bowel Syndrome
☐ Crohn's / Colitis
☐ Hernia
☐ Ulcers
☐ Gall Bladder Problems
☐ Liver Problems
☐ Kidney Infections
☐ Bladder Infections
☐ Urination Problems
☐ Poor Appetite
☐ Excessive Thirst

Skin:
☐ Allergies:
☐ Hypersensitivity
☐ Bruises Easily
☐ Rashes
☐ Eczema
☐ Psoriasis
☐ Athletes Foot
☐ Herpes
☐ Warts
☐ Skin Conditions:

Women:
☐ Pregnant, Due:
☐ Infertility
☐ Menstrual Concerns / Pain
☐ Menopausal Concerns
☐ Endometriosis
☐ Fibroids
☐ Hysterectomy
☐ Vaginal Pain / Infection

General Health:
☐ Good ☐ Fair ☐ Poor

Other (please list):

Head / Neck:
☐ Headaches
☐ Migraines
☐ Whiplash
☐ Jaw Pain
☐ Ear Pain
☐ Hearing Problems
☐ Hearing Loss
☐ Vision Problems
☐ Vision Loss
☐ Whiplash

Muscle / Joint:
☐Muscle Strain
☐ Ligament Sprain
☐ Spasms / Cramps
☐ Tendinitis
☐ Bursitis
☐ Fibromyalgia
☐ Ankylosing Spondylitis
☐ Arthritis OA RA
☐ Osteoporosis
☐ Herniated Disc
☐ Degenerative Discs
☐ Joint or Bone Disease
☐ Scoliosis
☐ Dislocation
☐ Fracture

Other Conditions:
☐ Diabetes, onset:
☐ HIV / AIDS
☐ Cancer
Type?
☐ Multiple Sclerosis
☐ Epilepsy
☐ Thyroid Disorders
☐ Lupus
☐ Loss of Sensation
Where?
☐ Insomnia / Fatigue
☐ Fainting / Dizziness
☐ Anxiety / Nervousness
☐ Depression
☐ Alcohol / Drug Addiction

Is there a family history of any of the conditions listed above?
Do you have any internal pins, wires, artificial joints or special equipment? ☐ Yes ☐ No
If yes, where?

Please ensure you read the following information in its entirety.

I have read the above information and certify all the information given on this form is true and accurately reflects my past and present conditions. I will update Charlene O'Grady, RMT regarding any updates in my condition, as soon as possible. I hereby request and consent to treatment.

In order to provide treatment, this clinic must collect personal health information. I understand that all information that I provide will be kept confidential unless allowed or required by law. I understand that I will be asked for written authorization before this information can be released.

I understand the 24 hour cancellation policy and agree to pay the missed appointment fee if I cancel within the 24 hour period preceding my appointment time. I understand that I am responsible to pay for the time reserved with Charlene O'Grady, RMT, regardless of the time I arrive and am ready for my appointment. I understand that this time will include intake, assessment, treatment, self-care recommendations, charting and administration. I understand that payment in full is due on the day of treatment.

Signature:_____ Date: _____

Signature of RMT:_____ Date: _____

Permission to verify information on issued receipt with patient's insurer? Yes ☐ No☐

Please mark on the diagrams with an 'X' your areas of concern.