Thrive Health History Form

Date of Initial Health History: _____
Update 1: _____
Update 2: _____
Update 3: _____
Update 4: _____

The information request below will assist us 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: _____ Phone #: _____
Address: _____ Postal Code: _____
Date of Birth: _____ Occupation: _____
Were you referred by anyone? _____
Have you received Massage Therapy before?(please circle one): Yes No

Please indicate conditions you are experiencing or have experienced:

Cardiovascular

- ❑ high blood pressure
- ❑ low blood pressure
- ❑ chronic congestive heart failure
- ❑ heart attack
- ❑ phlebitis/varicose veins
- ❑ stroke/CVA
- ❑ pacemaker or similar device
- ❑ heart disease
- ❑ is there a family history of any of the above? _____

Infections/Skin Conditions

- ❑ Hepatitis
- ❑ TB
- ❑ HIV
- ❑ Herpes
- ❑ Excema
- ❑ Psoriasis
- ❑ Contact Dermatitis
- ❑ is there a family history of any of the above? _____

Other Conditions

- ❑ Loss of sensation, where? _____
- ❑ Diabetes, onset: _____
- ❑ Allergies/hypersensitivity, to what? _____
- ❑ Cancer, where? _____
- ❑ Arthritis
- ❑ Is there a family history of arthritis? _____

Do you have or have you experienced pain/discomfort in the following areas?

- ❑ Neck
- ❑ Low back
- ❑ mid back
- ❑ upper back
- ❑ shoulders
- ❑ arms
- ❑ legs
- ❑ knees
- ❑ hips
- ❑ Feet
- ❑ Toes

Overall, how is your general health?_____

Primary Care Physician:_____Address:_____

Current Medications:_____

Are you currently receiving treatment from another health care professional? Yes No

If yes, for what?_____

Do you have any other medical conditions? Yes No

What?_____

Do you have any internal pins, wires, artificial joints or special equipment? Yes No

What & where?_____

What is the reason you are seeking Massage Therapy _____

_____

Injury- date & nature: _____

Surgery- date & nature: _____

Please sign after you have consulted with your RMT about the nature of the treatment you will receive.

I, _____ consent to the treatment as described and explained to me by my Massage Therapist. I acknowledge that he/she has provided me with information pertinent to the treatment and agree to receive it. I understand that my Massage Therapist will collect personal information to provide care, to help assess health care needs, make recommendations, and to establish a baseline of healthcare information. I understand that any RMT that I consent to a treatment with at Thrive may have access to this form and my health care file but that no information will be shared with anyone without my prior consent. I understand that Thrive will retain this form for 10 years from the last contact as regulated by the CMTO.

Signature: _____

Date:_____