HUMBER
School of Hospitality, Recreation & Tourism

File #: _____

HEALTH HISTORY FORM

Please take some time to fill in the following health history form. The information you provide will allow us to ensure the massage therapy treatment you receive will be safe. As your health changes please let us know. The information you provide is confidential, except as required or allowed by law. You will be asked to provide written consent for the release of any information. If you have any questions as you read the following, please feel free to ask.

Name: _____ Date: _____
Address: _____ Tel: (home) _____
_____ Tel: (other) _____
City: _____ Postal Code: _____ Email: _____
Date of birth: _____ Age:_____ Occupation: _____

Reason for seeking massage therapy: _____

Is this your 1st Massage Therapy Treatment? ❑ Yes ❑No
Did a health care professional refer you for massage therapy? ❑ Yes ❑No
If yes, please provide their name and address_____
_____

Please check all that apply:

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? ❑ Yes ❑No

Respiratory
- ❑ Chronic cough
- ❑ Shortness of breath
- ❑ Bronchitis
- ❑ Emphysema
- ❑ Asthma

Is there a family history of any of the above? ❑ Yes ❑No

Infections
- ❑ Hepatitis
- ❑ Skin condition, what? _____
- ❑ Tuberculosis
- ❑ HIV
- ❑ Herpes

Other Conditions
- ❑ Loss of sensation, where? _____
- ❑ Allergies/ hypersensitivity, what? _____ Type of reaction: _____ _____
- ❑ Diabetes, onset: _____
- ❑ Epilepsy
- ❑ Cancer, where? _____
- ❑ Osteoarthritis
- ❑ Rheumatoid arthritis

Is there a family history of arthritis? ❑ Yes ❑No

Head/ Neck
- ❑ Headache
- ❑ Eye problems
- ❑ Vision loss
- ❑ Ear problems
- ❑ Hearing loss

Women
- ❑ Pregnant, due: _____
- ❑ Gynaecological conditions, what? _____

Overall, how is your general health? _____

Primary Care Physician: _____
Address: _____
_____
Phone: _____

Other side ➲

File #: _____

Other medical conditions (e.g. sleep disturbances, gynecological conditions, hemophilia, etc):

_____

_____

_____

_____

Current Medications:

Name	For what condition

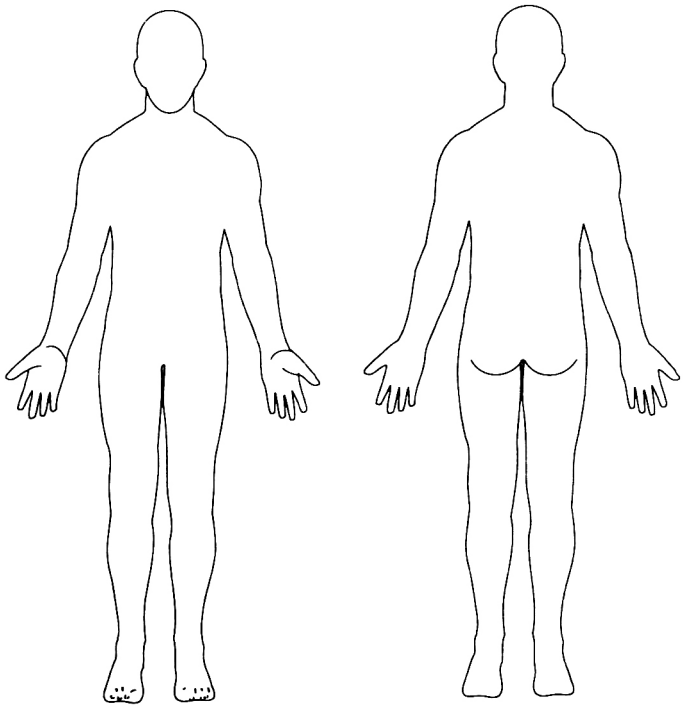
Previous Surgery:_____
Date:_____

Previous Injury:_____
Date:_____

Of Special Note (e.g. pins, plates, pace maker, glasses, ambulatory aids): _____

_____

_____



Please indicate areas of pain, stiffness, numbness, etc.

Consent for Collection, Use and Disclosure of Personal Health Information and Communication

I _____ understand that, in order to provide me with massage therapy treatments, Humber College Massage Therapy Clinic, as a Health Information Custodian (HIC), will collect personal information from me.

☐ I have reviewed the written statement indicating the purposes for collection, use, and disclosure of my personal health information. I understand that the Humber College Massage Therapy Clinic will only collect, use and disclose my personal information with my consent, for the purposes indicated in the written statement, unless the collection, use or disclosure is required or permitted by law without my consent.

☐ I consent to the Humber College Massage Therapy Clinic contacting me by phone and email regarding my appointment and related health information, upcoming opportunities for research, education and treatment, and other events related to the Massage Therapy Clinic, Massage Therapy program and Humber College.

Signature: _____ Date: _____