HUMBER
School of Hospitality,
Recreation & Tourism

File #: ____________

HEALTH HISTORY FORM

Please complete this health history form for the individual who will receive the massage therapy treatment. Please take some time to fill in the following health history form to the best of your ability. 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. All of the information you provide for this treatment 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 do not hesitate to ask for help or clarification.

Name: ______________________ Date: ______________________
Address: ______________________ Tel: (home) ______________________
______________________ Tel: (other) ______________________
Date of birth: ____________ Age: ________ Email: ______________________
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 #: ___________

Is there any other information the Massage Therapist should know about this individual (e.g. injuries, medications, illnesses, sleep disturbances, etc.):____

____

____

____

____

Information is current (fill out annually):

Signature	Date

Consent for Collection, Use and Disclosure of Personal Health Information

I _______________________________ *(Substitute Decision Maker)* understand that, in order to provide this individual with massage therapy treatments, Humber College Massage Therapy Clinic, as a Health Information Custodian (HIC), will collect personal information from me and the person I am Substitute Decision Maker for.

I have reviewed the written statement indicating the purposes for collection, use, and disclosure of my, and this individual's, 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.

Signature: _________________________________ Date: ______________________

Assent/Consent for Massage Therapy

I, _______________________________, Substitute Decision Maker for _______________________________, give my consent for this individual to receive massage therapy as a part of Humber College's Massage Therapy program. I understand that my Student Massage Therapist (SMT) will discuss with this individual the nature and purpose of the massage therapy provided and perform massage techniques. I understand that this individual can ask the SMT to stop or change what they are doing and may withdraw consent for treatment at any time for any reason.

Signature: _________________________________ Date: ______________________