Health History Form

The information requested below is required by the College of Massage Therapists of Ontario (CMTO) and is necessary in order to provide a safe and effective massage therapy treatment. All information will be kept confidential unless your written permission is given, or as required by law. Please notify your therapist if your health or contact information changes.

Name: _____ Date: _____

Cell #: _____ Other phone: _____

Address: _____

Postal Code _____ Birth date: _____

Occupation: _____ Reason for massage: _____

Emergency contact name: _____ Phone: _____

Overall, how is your health? _____

Name and address of your primary care physician: _____

_____

Are you receiving any other health care? ☐ Yes ☐ No If yes, please explain: _____

_____

List all treatments and medications you have had or taken in the past 24 hours. _____

_____

List all medications you are taking and the conditions they treat. _____

_____

History of accidents/injury/surgery: _____

_____

Do you have any internal pins, wires, artificial joints or special equipment? If yes, please explain:

_____

Why are you seeking massage therapy? _____

_____

Please complete page 2.

Please check all that apply.

HEAD / NECK
- Headache ☐
- Migraine ☐
- Visual Disturbances ☐
- Contact lenses/glasses ☐
- Earaches ☐
- Hearing Problems ☐
- Jaw Pain / Dental Problems ☐
- Whiplash ☐

DIGESTIVE / URINARY
- Difficult Digestion ☐
- Constipation ☐
- Liver / Gallbladder ☐
- Kidney / Urinary ☐
- Diabetes (Type & Onset) ☐
- Hypoglycemia ☐
- Crohn's disease ☐
- Irritable bowel ☐
- Ulcers ☐

MUSCLE / JOINTS
- Neck ☐
- Low back ☐
- Mid back ☐
- Upper back ☐
- Shoulder ☐
- Hip ☐
- Knee ☐
- Ankle ☐
- Other_____

CARDIOVASCULAR
- High blood pressure ☐
- Low blood pressure ☐
- Chronic Congestive Heart Failure ☐
- Poor circulation ☐
- Heart disease ☐
- Phlebitis ☐
- Varicose Veins ☐
- Stroke ☐
- Heart attack ☐
- Pacemaker ☐
- Arteriosclerosis ☐
- Irregular heart beat ☐

SKIN
- Bruise easily ☐
- Eczema ☐
- Psoriasis ☐
- Sensitivity ☐
- Skin condition ☐ (*please specify*) _____
- Loss of sensation ☐ (*describe*) _____
- Athlete's foot ☐
- Cold sores ☐
- Plantar warts ☐

FEMALE
- Menstrual problems ☐
- Pregnancy ☐
- *Due date*:_____
- Menopausal problems ☐
- Gynaecological conditions ☐

OTHER
- Hemophiliac ☐
- Epilepsy ☐
- Cancer ☐
- *Location*_____
- Arthritis OA ☐ RA ☐
- *Family history*_____
- Fibromyalgia ☐
- Osteoporosis ☐
- Chronic fatigue syndrome ☐
- Scoliosis ☐
- Carpal tunnel syndrome ☐
- Fainting/dizziness/loss of consciousness ☐
- Hernia ☐

RESPIRATORY
- Asthma ☐
- Chronic cough ☐
- Shortness of breath ☐
- Bronchitis ☐
- Emphysema ☐
- Smoker ☐

INFECTIOUS CONDITIONS

Tuberculosis	Y	N
AIDA/HIV	Y	N
Hepatitis	Y	N
Type_____		
Infectious skin condition(s) _____	Y	N

How is your general health?_____

Additional Information:_____

_____

This is to confirm and acknowledge that the above-mentioned information is correct and accurate to my knowledge and that I give consent for my treatment by a Registered Massage Therapist.

Signature:_____ Date:_____

Email:_____