THE STUDY
Movement & Wellness

Intake Form – Health History (Massage / Medical Exercise)

Please Note:
An accurate health history is important to ensure that it is safe for you to receive different forms of therapy. If your health status changes in the future, please let us know. All information gathered for this treatment is confidential except as required or allowed by law or except to facilitate diagnosis(assessment) or treatment. you will be asked to provide written authorization for release of any information.

Name: _____

Date of Birth: _____

Address: _____ **City:**_____ **Postal Code:**_____

Occupation: _____

Email: _____

*****Please note:**
Your email may be used to send rehabilitation exercises or treatment information

Please list any medications or supplements you are currently taking:

_____

_____

_____

Current Stress Level (Circle): Low Moderate High

Current Health Status (Circle): Poor Below-Average Average Good Great

Current Sleep Quality (Circle): Poor Below-Average Average Good Great

Current Energy Levels (Circle): Low Moderate High

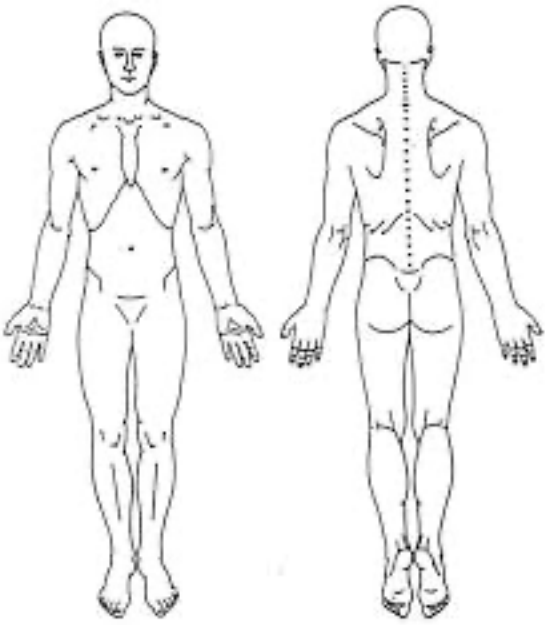
Primary Complaint:

How long have you had this condition or these symptoms:

Aggravating Factors (Things That Make It Worse):

Relieving Factors (Things That Make It Better):

<u>Please Indicate Areas of Concern:</u>



Discomfort/Pain Characteristics:

- ☐ Sharp
- ☐ Shooting
- ☐ Stabbing
- ☐ Throbbing
- ☐ Achy
- ☐ Numb
- ☐ Tingling
- ☐ Burning
- ☐ Hot
- ☐ Cold
- ☐ Deep
- ☐ Superficial

If multiple areas of concern, please specify which areas for each characteristic

Please Check all that Apply Currently, or have in the Past:

Cardiovascular

- ☐ Diabetes Type I
- ☐ Diabetes Type II
- ☐ High blood pressure
- ☐ Low blood pressure
- ☐ Chronic congestive heart failure
- ☐ Heart attack
- ☐ Stroke
- ☐ Aneurysm
- ☐ Varicose veins
- ☐ Heart disease
- ☐ Pacemaker
- ☐ Bruise easily
- ☐ Raynaud's
- ☐ Hemophilia

Respiratory:

- ☐ Chronic cough
- ☐ Shortness of breath
- ☐ Asthma
- ☐ COPD
- ☐ Bronchitis
- ☐ Emphysema
- ☐ Tuberculosis
- ☐ Sinusitis

Digestive:

- ☐ Constipation
- ☐ Irritable bowel syndrome
- ☐ Inflammatory bowel disease
- ☐ Crohn's Disease
- ☐ Ulcerative Colitis
- ☐ Colostomy Bag

Neurological

- ☐ Neuralgia
- ☐ Epilepsy
- ☐ Sensory loss
- ☐ Hypersensitivity
- ☐ Dizziness
- ☐ Fainting
- ☐ Parkinson's
- ☐ Multiple Sclerosis
- ☐ Cerebral Palsy
- ☐ Bell's Palsy
- ☐ Hemiplegia
- ☐ Spinal Injury

Head / Neck

- ☐ Dizziness
- ☐ Fainting
- ☐ Headaches
- ☐ Migraines
- ☐ Concussion
- ☐ Torticollis
- ☐ Vision loss
- ☐ Hearing loss
- ☐ Ear problems
- ☐ Corrective lenses / contacts

Mental Health:

- ☐ Anxiety
- ☐ Depression
- ☐ Claustrophobia
- ☐ Insomnia
- ☐ Other Sleep Disorder(s)

Other Conditions:

- ☐ Osteoporosis
- ☐ Osteoarthritis
- ☐ Rheumatoid Arthritis
- ☐ Fibromyalgia
- ☐ Chronic Fatigue Syndrome
- ☐ Hyperthyroidism
- ☐ Hypothyroidism
- ☐ Lupus
- ☐ Kidney Disease
- ☐ Urinary Condition
- ☐ Cancer
- ☐ HIV / AIDS
- ☐ Edema
- ☐ Plantar Warts
- ☐ Hepatitis
- ☐ TB
- ☐ Herpes
- ☐ Anemia
- ☐ Clotting Disorders
- ☐ Decubitus Ulcers
- ☐ Eczema
- ☐ Fungal Infections
- ☐ Psoriasis
- ☐ Skin Conditions (Other)_____

Pregnancy:

- ☐ Past
  Ages of Children:
  _____
- ☐ Current
- ☐ Not Applicable

Joint Muscle and Nerve – Check all that apply and Identify location (Right/Left)

- ☐ Cruciate and / or meniscal injuries
- ☐ Dislocation
- ☐ Fracture
- ☐ Scar tissue
- ☐ Strain
- ☐ Sprain
- ☐ Whiplash
- ☐ Wounds and/or Burns
- ☐ Degenerative Disc Disease
- ☐ Scoliosis
- ☐ TMJ Disorder
- ☐ Compartment Syndrome
- ☐ Frozen shoulder
- ☐ Plantar Fasciitis
- ☐ Shin Splints (Periostitis Syndrome)
- ☐ Tendonitis / Tendinosis
- ☐ Carpal Tunnel Syndrome
- ☐ Peripheral Neuropathy
- ☐ Sciatica
- ☐ Thoracic Outlet Syndrome

Other conditions not listed:

Known Allergies (medication/food/oils/lotions/seasonal):

Family history of medical conditions (please list below):

Check Any Surgeries that Apply

- ☐ Fractures
- ☐ Rods
- ☐ Pins
- ☐ Plates
- ☐ Shunts
- ☐ Implants
- ☐ Transplants

Surgery details:

Other Therapy / Treatment – Past or Present:

- ☐ Massage Therapy
- ☐ Chiropractor
- ☐ Physiotherapy
- ☐ Naturopath
- ☐ Acupuncture
- ☐ Other _____

List any Activities/Sports/Hobbies (strength training, yoga, walking, stretching, reading, knitting, painting etc.):

Signature of Client / Guardian

By voluntarily signing below, I declare that all information provided in this Health History Intake Form is accurate and updated. I understand that the information I have provided on this form will be kept completely confidential and will not be released without my written consent.

_____ _____

Signature **Date**

Informed Consent - Massage Therapy

I am requesting registered massage therapy treatment and I am providing the registered massage therapist at The Study consent for massage therapy treatments:

1. I understand that registered massage therapy is a physical hands on therapy that is provided for the purposes of developing, maintaining, rehabilitating or augmenting physical function, relieving pain or promoting health. My registered massage therapist will provide assessment and treatment of soft tissues and/or joints of the body by manipulation, mobilization and other manual methods.

2. I understand that registered massage therapy treatments involve an assessment, manual massage, a treatment plan and home care (as required or requested). I understand that my treatment plan will be created with my goals and expectations in mind.

3. I understand that my registered massage therapist will work within my pain threshold and will not work on areas that I am uncomfortable with. My treatment will be modified for pain and discomfort and my registered massage therapist will only use a pressure that I am comfortable with. If I am not comfortable with the pressure used I will express that to my registered massage therapist at any time during the treatment and my registered massage therapist will modify the treatment accordingly.

If I am not comfortable with any areas of my body being treated I will indicate that to my registered massage therapist, before or, should anything change, during the treatment. The areas that are not being treated at the time will be fully draped for the duration of the treatment.

4. I am aware that I am entitled to ask questions about the treatment, techniques, my treatment plan and that I can modify or end the treatment at any time.

5. I understand that I can withdraw consent verbally at any point during the treatment and that my registered massage therapist will discontinue treatment at that time.

6. I understand that I have the right to make my own decisions about my health care. My therapist will however, provide input regrading my treatment and my treatment plan to provide shared decision making based on my best interests. All decisions about my health care are ultimately my choice.

7. I understand that no area of my body will be treated without my approval and consent at the time of treatment.

8. As part of a therapeutic treatment I am aware that my registered massage therapist may request permission to work on my: head, face, neck, arms, hands, fingers, back, buttocks, chest, breasts, torso, abdomen, pelvis, thighs, lower legs, feet, and toes.
I can verbally deny or revoke permission for work on any area at any time.

9. The registered massage therapist has explained to me and I fully understand the proposed treatment including: the nature of any assessment, the reasons for treatment of any of the above areas, the expected benefits of the treatment, the potential risks of the treatment, the potential side effects of the treatment, alternative courses of action, likely consequence of not having the treatment, that consent is voluntary and that I can withdraw my consent at any time.

10. I am providing consent for massage therapy assessment and treatment and I understand that my consent can be revoked either verbally or in writing at any point in time. I also accept that I have a responsibility to verbalize to my therapist if I am uncomfortable, in pain or in the event that I would like to revoke consent for any or all of the treatment.

Informed Consent to Treatment

I hereby request, and authorize, to receive massage therapy treatments including assessments, examinations, modalities, and techniques that are within the scope of practice of the registered massage therapist. These modalities and techniques may include, but are not limited to, relaxation / deep tissue / therapeutic massage therapy, hot/cold hydrotherapy, myofascial cupping, myofascial release, graston techniques, k-taping techniques, active release techniques, TMJ treatments.

Depending on the condition(s) being treated, a practitioner may require treating sensitive areas, and thus, requires consent for the treatment of these sensitive areas:
Gluteals (buttocks, low back and hip region, sacrum, coccyx)
Abdomen and Lower Abdomen (including access to the pubic bone)
Medial (Inner) Thigh
Groin
Pectorals
Intra-oral (inner jaw for specified TMJ Dysfunction Treatments)

I have been informed that after receiving a massage therapy treatment, i may experience temporary side effects, including, but not limited to muscle soreness and tenderness, cupping marks, light headedness upon getting up form the treatment table, general fatigue and/ or allergic reaction to oils, lotions, or creams used during treatment. i confirm that i have disclosed to the practitioner, all of my major and minor allergies. i understand that while this document describes the above risks of treatment, others side effects may occur.

I have been educated in the potential benefits of regular/consistent treatments, including but not limited to, relief of my presenting symptoms, enhanced relaxation, reduced stress levels, improved circulation, increased rand of motion and reduced pain from muscular tension and spasm, which may lead to preventing further progressions or elimination of the presenting problems. i understand that results are not guaranteed

I Voluntarily give my consent for the treatment as discussed with my registered massage therapist and outlined above

_____ _____

Signature Date

_____

Signature of Parent or Guardian of Minor