Oxford Massage Therapy

SUSAN BERG, RMT

Confidential Case History

An accurate health history is important to ensure that it is safe for you to receive a massage therapy treatment. The CMTO requires that this history be updated on a yearly basis. If your health status changes in the future, please inform your therapist. All information is confidential except as required or allowed by law or to facilitate assessment of treatment.

NAME: _____ ADDRESS: _____

CITY: _____ POSTAL CODE: _____

PHONE / CELL NUMBER: _____ DATE OF BIRTH: _____

OCCUPATION: _____ EMAIL ADDRESS: _____

FAMILY PHYSICIAN & ADDRESS: _____

ALLERGIES: _____ CURRENT MEDICATIONS: _____

Are you currently being treated by another health care professional? ☐ Yes ☐ No _____

Have you received massage therapy before? ☐ Yes ☐ No _____

SOURCE OF REFERRAL: _____

CHIEF COMPLAINTS: _____

TYPE OF PAIN: _____ DOES IT RADIATE? _____ WHERE? _____

WHAT RELIEVES PAIN/CONDITION? _____

WHAT AGGRAVATES PAIN/CONDITION? _____

OTHER THERAPIES? _____

DESCRIBE & DATE PAST INJURIES/SURGERIES: _____

MOTOR VEHICLE ACCIDENT: ☐ Yes ☐ No DATE(S): _____

EMERGENCY CONTACT: _____ PHONE NUMBER: _____

Health History - Please check the conditions that apply:

HEAD/NECK
- ☐ headaches - tension/migraine
- ☐ vision problems
- ☐ hearing problems
- ☐ ear/jaw/tooth pain
- ☐ head trauma/concussion
- ☐ allergies
- ☐ neck pain/stiffness/injury

SKIN
- ☐ sensitive skin
- ☐ rashes/eruptions
- ☐ cold sores
- ☐ contagious conditions
- ☐ bruise easily

DIGESTIVE
- ☐ poor appetite
- ☐ constipation/diarrhea
- ☐ nausea
- ☐ gas
- ☐ liver/gallbladder
- ☐ ulcer
- ☐ alcohol consumption

RESPIRATORY
- ☐ chronic cough
- ☐ congestion
- ☐ asthma or bronchitis
- ☐ shortness of breath
- ☐ family history of any of above

CARDIOVASCULAR
- ☐ high blood pressure
- ☐ low blood pressure
  - ☐ poor circulation
- ☐ congestive heart failure
- ☐ varicose veins/phlebitis
- ☐ dizziness
- ☐ chest pain/angina
- ☐ heart disease
- ☐ heart attach/stroke
- ☐ family history of any of above

OTHER
- ☐ cancer
- ☐ epilepsy/seizures
- ☐ hepatitis
- ☐ HIV
- ☐ hemophilia
- ☐ lupus
- ☐ diabetes
- ☐ Other: _____

MUSCLES/JOINTS/NERVES
- ☐ swelling
- ☐ limitation of movement
  - ☐ fibromyalgia
- ☐ chronic fatigue syndrome
- ☐ pain/stiffness/injury
  - ☐ neck ☐ arm/shoulder
  - ☐ mid back ☐ hip/thigh
  - ☐ low back ☐ knee/leg
- ☐ multiple sclerosis
- ☐ degenerative disc disease
- ☐ spasm/strain/sprain
- ☐ tendonitis/bursitis
- ☐ fractures/pins/wires/plates
  - ☐ artificial joints
- ☐ sports/work-related injury
- ☐ repetitive strain injury
- ☐ carpal tunnel syndrome
- ☐ osteparthritis/rheumatoid arthritis
- ☐ family history of any of above

ARE YOU PREGNANT? ☐ Yes ☐ No

IF YES, DUE DATE: _____

GYNAECOLOGICAL CONDITIONS, WHAT? _____

OVERALL, how is your health? _____

Due to the high client volumes in the clinic, waiting lists exist. We find it necessary to impliment a no show or cancelled appointment with less than 24 hours notice. A fee of $25.00 for every half hour of scheduled time. It is your responsibility to attend your appointment. Please initial upon reading this. Thank you for your cooperation. I understand and initial this cancellation policy.

_____

Release of Personal Information
I hereby fully authorize the Registered Massage Therapist to exchange medical and/or other information necessary with other medical professionals handling my case, WSIB (if applicable), and /or my motor vehicle auto insurance company (if applicable) and any third party payers and benefit plan Insurance companies.

I understand that this information will be used to provide me with the most individualized and optimal massage therapy treatment care and will be confidential.

Consent for Treatment
I hereby offer my consent to participating in massage therapy treatment, which I have been told may include pain control modalities, exercise prescription, manual therapy, passive muscle stretching, and health care education/teaching.

I understand that I may withdraw my consent at any time without penalty.

☐ **I HAVE READ AND ACKNOWLEDGED THE PRIVACY POLICY OF THIS MASSAGE THERAPY PRACTICE.**

_____ _____
Signed Consent (Signature) Date

_____
(COMPLETE THIS NEXT PORTION ONLY IF APPLICABLE)

_____
I understand that by signing this form that I am choosing to proceed with the treatment and/or treatment plan proposed at this time, I understand that I may change my mind, after, or refuse treatment at any time during this or any other treatment. This completed form will be kept in my client file, held by my RMT.

Please read and sign:

I have been informed of and have understood the reason(s) for receiving massage to my

☐ _____ buttock(s) (gluteal muscles)

☐ _____ inner thigh(s)

☐ _____ chest wall muscles

☐ _____ breast tissue

Regarding massage of the breast(s), I have been informed of the clinical indicators for breast massage that relate to my situation:

_____ (Massage Therapy Standards of Practice).

As well, I understand that the nipples and/or areolas of my breasts will not be touched during the breast massage.

For any of the above areas that I have checked off and initialed, I have been informed of the reasons, the benefits, risks, and side effects, and the proposed draping (covering). In addition, I have had all of my questions regarding this treatment answered by the massage therapist.

I understand that I can alter or rescind my consent at any time during this or any treatment. At this time, I am voluntarily giving my consent for the treatment and/or treatment plan as discussed with me.

_____ _____
Signed Consent (Signature) Date

Privacy Policy

I, _____, Registered Massage Therapist am committed to respecting the privacy of individuals and recognized the need of people with whom I do business (patients, clients, health care providers, third party payers) for the appropriate management and protection of any Personal Information that you agree to provide to me.

My Privacy Policy outlines the guidelines on the collection, storage, use and retention of your Personal Information as follows:

- **Collection:** My Massage Therapy practice will collect patients' personal information in order to better understand your health history and provide you with Massage Therapy Treatment. I will make all reasonable efforts to fully inform my clients about the planned use or disclosure. I will limit the collection and use of personal information to that required for valid Massage Therapy practice purposes or to comply with legislation.
- **Accuracy:** My practice will make every reasonable effort ensure that the personal information it collects and uses is accurate and complete. Individuals providing personal information will have the opportunity to review and correct their personal information, and on written or verbal request by an individual to whom the information relates, I will modify the information as required.
- **Storage:** I will store personal information using a hard copy and/or electronic means in such a way as to prevent unauthorized collection, access, use, disclosure, or disposal of the personal information.
- **Retention:** I will retain your personal information for a minimum of ten years after the last treatment date for each individual, or if the individual is less than 18 years of age, personal information will be stored for 10 years after the individual turns 18. I will advise in writing, telephone or in person of any practice location changes and where individual personal information records will be stored.
- **Disclosure:** I will not disclose personal information unnecessarily to any third party, unless the effected individual consents.
- **Access:** I will promote an individual's patient's right of access to personal information about themselves. I will provide access to
  information upon request and within a reasonable time period. I will provide access to a third party if indicated by written request by the individual/patient.

In addition to the care that I, _____, RMT, takes directly to protect your personal information, I would require your authorization in case of an emergency while in attendance at my Massage Therapy practice to contact your emergency contact.

In case of a personal emergency for myself, I would require your authorization to allow a third party individual/s designated by me to have authorization to access your personal information to reschedule an appointment if applicable. In addition to this, any designated third party individual/s that in any way handle or manage Personal Information in my office have acknowledged and agreed to adhere to my Privacy Policy and procedures that support it.

If for any reason your personal information is compromised from a privacy or security aspect, I or a designated third party individual acting on behalf of my practice will inform you.

I, (Print Name) _____, hereby acknowledge and agree to adhere to the Privacy Policy and procedures of the Massage Therapy practice of _____, RMT, as her Administrative Assistant.

Signature _____