Ariyo
THAI MASSAGE CLINIC

Health History Form

"Where Spa & Wellness Unite"

The information request below will assist us in treating you safely. Feel free to ask any questions about the information being requested. Please note that all information provided below will be kept confidentially unless allowed or required by law. Your written permission will be required to release any information.

Name: _____ Phone: _____

Address: _____

Occupation: _____ Birth date: _____

Have you received massage therapy before? ☐ Yes ☐ No

Did a medical doctor refer you for massage therapy? ☐ Yes ☐ No

Please indicate conditions you are experiencing or have experienced:

Cardiovascular

- ☐ high blood pressure
- ☐ low blood pressure
- ☐ chronic congestive heart failure
- ☐ heart attack
- ☐ phlebitis/varicose veins
- ☐ stroke/CVA
- ☐ pacemaker or similar device
- ☐ heart disease
- ☐ thrombosis/aneurism
- ☐ family history of cardiovascular difficulties

Respiratory

- ☐ chronic cough
- ☐ shortness of breath
- ☐ bronchitis
- ☐ asthma
- ☐ emphysema
- ☐ family history of respiratory difficulties

Infections

- ☐ hepatitis Type:_____
- ☐ skin conditions: _____
- ☐ Infectious respiratory conditions
- ☐ HIV
- ☐ herpes

Other Conditions

- ☐ loss of sensation... Where? _____
- ☐ diabetes, onset: _____
- ☐ allergies/hypersensitivity to what? _____ type of reaction: _____
- ☐ epilepsy
- ☐ cancer, where? _____
- ☐ skin conditions, what? _____
- ☐ arthritis
- ☐ family history of arthritis?
- ☐ lumbar spinal stenosis, spondylitis, or spondylothesis

Head/Neck

- ☐ history of headaches
- ☐ history of migraines

Women

- ☐ trying to conceive
- ☐ pregnant, due?_____
- ☐ gynaecological conditions? _____

Overall, how is your general health? _____

Primary Care Physician:

_____

Address:

_____

_____

_____

Current Medications:

_____

Condition it treats: _____

_____

Are you currently receiving treatment from another health care professional? ☐ Yes ☐ No

If yes, for what? _____

_____

Surgery - Date: _____

Nature: _____

Injury - Date: _____

Nature: _____

_____

Do you have any other medical conditions? (i.e. digestive, haemophilia, osteoporosis, mental illness) ☐ Yes ☐ No

What? _____

Do you have any internal pins, wires, artificial joints, implants within 9 months, or special equipment? ☐ Yes ☐ No

what? _____

where? _____

What is the reason you are seeking massage therapy? Please include the location of any tissue or joint discomfort. _____

_____

_____

*Notes: (Office use only)

Consent for Clinical Policies

*I will update my massage therapist of any changes in my health status whenever they occur.
*I am responsible to communicate with my massage therapist during the course of treatments; and encouraged to ask questions or stop treatments at any time.
*I agree to the "service fees" posted in the reception area. I am responsible for the payments of full scheduled appointments, even if I cause the delay of treatment time.
*I agree to the "cancellation policy" posted in the reception area.
*I am aware that this clinic is a scent-free and shoes-free environment.

Client Signature: _____Today's Date: _____ / _____ / _____ (YYYY/MM/DD)

Consent for Assessment and Treatment of Sensitive Areas

I, _____ , have requested assessment and/or treatment by
(Client's full name)
this Registered Massage Therapist (RMT) , Erin Chou for treatment of the clinically relevant areas indicated below (please initial):

_____ Buttocks (gluteal muscles) _____Chest wall muscles _____ Upper inner thigh(s) _____ Breast(s)

List clinical indications: _____

The RMT has explained the following to me and I fully understand the proposed assessment and/or treatment:

- The nature of the assessment, including the clinical reason(s) for assessment of the above area(s) and the draping methods to be used.
- The expected benefits, potential risks and side effects of the assessment.
- That I can withdraw or alter my consent at any time.

I voluntarily give my informed consent for the assessment and/or treatment as discussed and outlined above.

Client Signature: _____ Date: _____

Ongoing Treatment:
I am aware that the treatment of the above indicated area(s) is part of a treatment plan which has been discussed with me by RMT. I confirm that, on the following date(s), the RMT has reviewed the treatment plan and that I provide my informed consent.

Client Signature: _____ Date: _____

Client Signature: _____ Date: _____

Client Signature: _____ Date: _____

Client Signature: _____ Date: _____

Client Signature: _____ Date: _____

Client Signature: _____ Date: _____