NORTH TORONTO RMT CLINIC
YOUR PAIN · OUR MANAGEMENT

416.419.8995
appt@northTOrmt.com
https://northtormt.com

New Patient Health History Registered Massage Therapy Form

An accurate health history form is important to ensure that it is safe for you to receive treatment. If your health status changes in the future, please let us know. All information 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: first ____________________ Middle ____________________ Last ________________________ Sex: ☐M ☐F

Address: ___________________________________Suite# _________ Email:___________________________

City: ___________________Province: ____________Postal Code: ________________

Mobile: _________________ Home: _________________ Business: _________________

Date of Birth (YYYY _________ / MM _________ / DD _________) Weight: _________ Height: ________

How did you hear about the clinic: __________________________Overall General Health: ______________________________

What is your primary complaint?

____

PLEASE INDICATE CONDITIONS YOU ARE EXPERIENCING OR HAVE EXPERIENCED.

MUSCLES/JOINTS Pain/Stiffness

☐NECK ☐ARMS: ☐left/☐right

☐UPPER BACK ☐LEGS: ☐left/☐right

☐MID BACK ☐KNEES: ☐left/☐right

☐LOW BACK ☐HIPS: ☐left/☐right

☐SHOULDERS ☐Other:

HEAD/NECK

☐headaches: type:

☐vision problems/vision loss

☐earaches/ear problems

☐hearing loss

RESPIRATORY

☐chronic cough ☐bronchitis

☐shortness of breath ☐asthma

☐smoking ☐emphysema

COMMUNICABLE DISEASES

☐COVID-19 ☐TB ☐HIV (AIDS)

specify: ______________________

FEMALE

☐pregnant: Due Date: ________________

CARDIOVASCULAR CURRENT

☐blood pressure: ☐high or ☐low

☐poor circulation

☐heart disease

type

☐stroke

☐pacemaker or similar device

☐hemophilia

☐varicose veins

OTHER CONDITIONS

☐sinus

☐epilepsy

☐diabetes

☐allergies

specify: _____________________

☐cancer

specify: ______________________

☐arthritis: ______________________

specify: ______________________

☐Other conditions

specify: ______________________

☐Children: number: ____

MEDICATIONS

List Name and Condition

____

____

____

SURGERIES

Type: ____________

Date: ________________

Current Symptoms:

____

____

INJURIES/MOTOR VEHICLE ACCIDENTS

Date: ________________

Current Symptoms: ____________

____

OTHER HEALTH CARE skin

☐Chiropractic

☐Regular Exercise

☐Physiotherapy

☐Reflexology

PHYSICIAN: _________________________ Date of Last Visit: ______________

Address: _________________________ OTHER MEDICAL CONDITIONS: e.g. ☐digestive conditions, ☐thyroid problems, ☐nervous system, ☐endocrine system, etc._Other SPECIAL NOTE: ☐internal pins, ☐wires, ☐artificial joints, ☐Special equipment: ____________________

CANCELLATION POLICY: A $25 cancellation service charge will apply if less than 48 hours' notice has been given. The clinic will gladly assist you in understanding your insurance, but you agree that you are responsible for your account.

☐CONSENT TO TREATMENT: **DATE:** __________________ **Signature** (*Type Your Name*) : ____________________