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: _____
PHYSICIAN: _____

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: ____
Date of Last Visit: _____

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

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*) : _____

Submit