Jen Abbotts, RMT
658 Danforth Ave Suite 301A, Toronto, ON M4J 5B9
647-994-6457

Health History

According to provincial legislation, it is my duty as an RMT to obtain your informed consent regarding the collection, use and disclosure of personal information (including health information). This information is collected for the purposes outlined in my privacy policy, which is displayed in my treatment space — namely for the safe and effective construction of treatment. This is a snapshot of your health as it has been and is today — should your health change in any way, please keep me informed so that I can update your information and provide you with the safest and most effective treatment possible. Should you have any questions, please do not hesitate to ask.

Consent For Collection Of Personal Information

I understand that in order to provide me with safe and effective massage treatments, Jennifer Abbotts will collect personal information about me (eg. personal contact info, health history information). I have had the opportunity to review the privacy policy about the collection, use and disclosure of personal information, steps taken to protect personal information, and my rights regarding accessing and correcting my personal information. I understand that I can refuse to sign my consent on this form. I can also withdraw my consent at anytime by writing to Jennifer Abbotts. Without access to the information requested on this form, however, Jennifer will be unable to offer me treatment. I agree to Jennifer Abbotts collecting, using and disclosing personal and health information about me (with my health care team) as set out in her privacy policy.

Signature _____ Date_____

Name:_____ Occupation:_____

Date of Birth (MM/DD/YYYY):_____ Phone: _____

Address: _____

Email: _____

Doctor's Name: _____ Doctor's Phone: _____

Last Doctor Visit: _____

What brings you in for massage therapy today?

_____

Current Medications

Please include pills, injections, hormonals, prescribed or over-the-counter medications.

Drug name:	Used for:
_____	_____
_____	_____
_____	_____
_____	_____

Do you take remedies and/or supplements?
O Yes O No

Remedy/Supplement:	Used for:
_____	_____
_____	_____
_____	_____

Special Considerations

Please check any that apply.

O Pacemaker O Cane, walker

O Artificial valve O Wheelchair

O Artificial joints

O Artificial limb(s)

O Medication patch

O Crutches

O Rods, pins, wires

O Chemo/drug port

O Breast implants

O Other: _____

Please check any that apply:

Respiratory
O Bronchitis/chronic cough
O Asthma
O Emphysema
O Other:_____

Cardiovascular
O High blood pressure
O Low blood pressure
O Angina
O Heart attack
O Congestive heart failure
O Phlebitis
O Poor circulation
O Other:_____

Central Nervous System
O Epilepsy
O TIA/stroke
O Multiple Sclerosis
O Parkinsonism
O Other: _____

Infectious Conditions
O Hepatitis Type:_____
O HIV/AIDS
O Tuberculosis
O Other: _____

Skin
O Warts
O Herpes
O Eczema
O Psoriasis
O Other: _____

Allergies
O Nuts
O Herbs
O Oils, creams, lotions
O Aromas, airborne
O Latex
O Drug Allergy
O History of anaphylaxis
O Other: _____

Please check any that apply:
C = Current, P = Previous

Musculoskeltal
O C O P Neck Problem
O C O P Shoulder Problem
O C O P Arm Problem
O C O P Wrist Problem
O C O P Hand Problem
O C O P Mid Back Problem
O C O P Low Back Problem
O C O P Hip Problem
O C O P Knee Problem
O C O P Ankle Problem
O C O P Foot Problem

O Altered Sensation
Where? _____

O Arthritis
Where? _____

O Headaches
Type? _____

How often? _____

Surgeries
Year Type
_____ _____
_____ _____
_____ _____

Current complications?
O Yes O No

Injuries
Year Type
_____ _____
_____ _____
_____ _____
_____ _____

Current complications?
O Yes O No

O Regular Exercise
What type(s)?
_____

Please check any that apply:
C = Current, P = Previous

O Diabetes
Type? _____
Year diagnosed? _____
Current complications:
_____

O Cancer
Type? _____
Year diagnosed? _____
Current complications:
_____

Hearing/Vision

O Visual Impairment
O Hearing Impairment

Digestion/Urination

O Constipation
O Irritable Bowel Syndrome
O Crohn's Disease
O Kidney Disease
O Recurrent Infection
O Prostate Problem
O Other: _____

Women

O Pregnant Due: _____
O Menstruation Issues
O Menopause Issues
O Breast Pain
O Breastfeeding
O Endometriosis
O Other: _____

Other Health Care

O C O P Physiotherapy
O C O P Chiropractic
O C O P Naturopathy
O C O P Psychotherapy
O C O P Medical Specialist
O C O P Other: _____

I attest that the Health History information that I have provided is accurate to the best of my knowledge.

Signature: _____ Date: _____