



## REGISTERED MASSAGE THERAPY INITIAL ASSESSMENT

Name: \_\_\_\_\_

Address: \_\_\_\_\_

City/Town \_\_\_\_\_ Postal Code \_\_\_\_\_

Email \_\_\_\_\_

Phone: Home \_\_\_\_\_ Work \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Occupation: \_\_\_\_\_

Family Doctor: \_\_\_\_\_

Emergency contact: \_\_\_\_\_ Phone: \_\_\_\_\_

How did you hear of us?: \_\_\_\_\_

Have you had massage therapy before?  Yes  No

If yes, did you suffer any adverse reactions?  Yes  No

Explain \_\_\_\_\_

Reason for visit: \_\_\_\_\_

### Funding:

#### 1. Private pay/EHC

A. Physician referral may be required – **advise patient**

#### 2. WSIB **\*obtain wsib approval prior to booking appointment**

A. Claim number \_\_\_\_\_ B. Adjudicator \_\_\_\_\_

C. Date of loss \_\_\_\_\_

#### 3. MVA **\*must bring 2 EHC signed forms or will have to pay for assessment themselves**

A. Insurance company \_\_\_\_\_ B. Address \_\_\_\_\_

C. Claim number \_\_\_\_\_ D. Adjuster \_\_\_\_\_

E. Date of loss \_\_\_\_\_

#### Price:

30 minutes	\$45.00 + GST = \$47.25
45 minutes	\$55.00 + GST = \$57.75
60 minutes	\$65.00 + GST = \$68.25
90 minutes	\$100.00 + GST = \$105.00

Cancellation Fee: \$25.00  
(less than 24 hours notice)

An accurate health history is important to ensure that it is safe for you to receive a massage treatment. If your health status changes in the future, please let me know. All information gathered for this treatment is confidential except to facilitate diagnosis (assessment) or treatment. You will be asked to provide written authorization for release of any information.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Please indicate if you prefer NOT to receive communications information from KBM. Yes / No  
Please turn over page to complete health history questionnaire.

## Health History

Check off any conditions that apply

<p><b>Respiratory</b></p> <p><input type="checkbox"/> chronic cough</p> <p><input type="checkbox"/> shortness of breath</p> <p><input type="checkbox"/> bronchitis</p> <p><input type="checkbox"/> asthma</p> <p><input type="checkbox"/> emphysema</p> <p><b>Cardiovascular</b></p> <p><input type="checkbox"/> high blood pressure</p> <p><input type="checkbox"/> low blood pressure</p> <p><input type="checkbox"/> CCHF</p> <p><input type="checkbox"/> heart attack</p> <p><input type="checkbox"/> phlebitis</p> <p><input type="checkbox"/> stroke/CVA</p> <p><input type="checkbox"/> pacemaker or similar device</p> <p><input type="checkbox"/> heart disease</p> <p><b>Skin</b></p> <p><input type="checkbox"/> skin conditions</p>	<p><b>Other Conditions</b></p> <p><input type="checkbox"/> loss of sensation</p> <p><input type="checkbox"/> diabetes (onset: _____)</p> <p><input type="checkbox"/> allergies(ie.anaphylaxis)</p> <p><input type="checkbox"/> skin irritation</p> <p><input type="checkbox"/> epilepsy</p> <p><input type="checkbox"/> cancer</p> <p><input type="checkbox"/> arthritis</p> <p><b>Head/Neck</b></p> <p><input type="checkbox"/> vision problems</p> <p><input type="checkbox"/> vision loss</p> <p><input type="checkbox"/> ear problems</p> <p><input type="checkbox"/> hearing loss</p> <p><b>Infections</b></p> <p><input type="checkbox"/> hepatitis</p> <p><input type="checkbox"/> skin conditions</p> <p><input type="checkbox"/> TB</p> <p><input type="checkbox"/> HIV</p>	<p><b>Women</b></p> <p><input type="checkbox"/> pregnant (due:_____)</p> <p>Number of children _____</p> <p><b>Soft tissue/joint discomfort and its nature</b></p> <p>neck _____</p> <p>low back _____</p> <p>mid back _____</p> <p>upper back _____</p> <p>shoulders _____</p> <p>arms _____</p> <p>legs _____</p> <p>knees _____</p> <p>other _____</p> <p>What is your general health status?</p> <p>_____</p>
---	--	---

Have you had any surgery? Date \_\_\_\_\_

Nature of surgery \_\_\_\_\_

Have you had an injury? Date \_\_\_\_\_

Nature of injury \_\_\_\_\_

Other Medical Conditions (e.g. digestive conditions, gynaecological conditions, hemophilia, etc.)

\_\_\_\_\_

Of Special Note: (presence of internal pins, wires, artificial joints, special equipment)

\_\_\_\_\_

Are you presently involved in other health care?  Yes  No

Explain \_\_\_\_\_

Current Medications (list)

\_\_\_\_\_

\_\_\_\_\_