Health History

Welcome to Natural Path Wellness Centre. Please complete this form in full.

All information is strictly confidential. Please print.

Name: _____ Date: _____

Date of Birth: M_____D_____Y_____ Preferred Pronoun/s _____

Address: _____

City: _____ Province: _____ Postal Code _____

Phone #: (___)_____ Cell # (___)_____ Work #: (___)_____

Employed / Self-Employed / Stay-At-Home Parent / Retired / Student_____

Current/Former Occupation: _____ Doctor: _____

Emerg. contact: _____ Relationship: _____ Phone #: _____

Email: _____ How did you hear about us? _____

Do you have an open insurance claim from a **motor vehicle accident** or other situation? ____ yes ___ no

Do you have an insurance plan to cover your massage therapy treatments? ____ yes ____ no

Company: _____

Group/Plan # _____ Member ID# _____

List any past surgeries, injuries, or accidents and approximate dates (including from childhood):

Date _____ Injury/Surgery _____

Date _____ Injury/Surgery_____

Date _____ Injury/Surgery_____

_____

_____

Please list **all** medications you are currently taking or recently discontinued (indicate):_____

_____

_____

Are you currently undergoing any other forms of treatment? __Yes __No

Please detail: _____

Do you exercise regularly? __Y __N what kind? _____

Pregnancy may affect how we are able to safely treat you, please indicate if you are Pregnant: Y / N

Trimester ____ Problems/Concerns associated with pregnancy? _____

*****Please note that many conditions overlap, for example, hip/pelvic issues and jaw pain. Please consider each area carefully!**

Pelvis/ Abdomen/ Hip Pain or Disorder

- ☐ Menstrual problems _____ yrs ____
- ☐ C Section/s # ____
- ☐ Vaginal Birth/s # ____
- ☐ Miscarriage/s # ____
- ☐ Ovarian
- ☐ Prostate
- ☐ Chronic Hip Pain
- ☐ Abdominal/groin/hip surgery
- ☐ Incontinence Bladder / Bowel
- ☐ Painful Bladder / Bowel
- ☐ Irritable Bowel Syndrome (IBS)
- ☐ Colitis/Crohn's Disease (IBD)
- ☐ Acid reflux
- ☐ Other: _____

Musculoskeletal

- ☐ Jaw Pain/TMJ
- ☐ Bone/Joint disease
- ☐ Tendonitis
- ☐ Bursitis
- ☐ Arthritis/Gout, specify _____
- ☐ Spinal problems/injuries_____
- ☐ Other: _____

Nervous System

- ☐ Numbness Tingling
- ☐ Shingles
- ☐ Epilepsy/Seizures
- ☐ Nerve Damage/Injury

Skin

- ☐ Allergies
- ☐ Rashes
- ☐ Athletes foot
- ☐ Herpes/Cold sore
- ☐ Other: _____

Other

- ☐ Anxiety__ stress__ Depression__
- ☐ Sleep disorders
- ☐ Migraines/headaches, type _____
- ☐ Diabetes, type _____
- ☐ Chronic fatigue
- ☐ Fibromyalgia
- ☐ Chronic pain _____
- ☐ Sudden loss of appetite
- ☐ Surgical Implants, specify _____
- ☐ Cancer/Tumors?

  Diagnosis_____

  Location _____

  Stage _____

Circulatory

- ☐ Blood thinners? Type _____
- ☐ Heart condition _____
- ☐ Phlebitis / Varicose Veins_____
- ☐ Blood Clots
- ☐ High / low blood pressure
- ☐ Lymphedema
- ☐ Thrombosis / Embolism

Respiratory Conditions

- ☐ Asthma
- ☐ Emphysema
- ☐ Allergies, specify: _____
- ☐ Sinus
- ☐ Other: _____

Do you presently have an infectious disease?____Y _____ N

Additional health comments: _____

_____

_____

What is your primary complaint for today's treatment?

_____

_____

I have stated all conditions that I am aware of and this information is true and accurate.

I will inform Natural Path Wellness Centre of any changes in my status.

Signature: _____ **Date:** _____

Health History Update whenever there is a long period between treatments

Please note any changes to your health history below, date and initial.

_____

_____

_____

_____

_____

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_____

_____

Informed Consent for Massage Therapy
Natural Path Wellness Ltd.

I _____ have informed the Massage Therapist of all my known physical conditions, mental conditions and medications, and I will keep NPW updated on any changes.

Initial _____

I understand that the possible risks and benefits of massage and areas to be treated will be explained to me regarding my individual treatment plan. I accept responsibility of informing my therapist if I do not understand any aspect of the risks and benefits or do not want certain areas treated.

Initial _____

Although major side effects are extremely rare, minor side effects can happen more frequently and are usually resolved in a day or two. These include but are not limited to; increased post treatment pain, possible bruising and nerve damage.
Clear communication with your therapist during treatment will help to avoid most complications.

Initial _____

Clients are invited to contact the clinic at any time with pre or post treatment questions. I understand that massage therapy is not a substitute for medical treatment or medications, and that it is recommended that I work concurrently with my Primary Caregiver for any condition that I have. I am aware that diagnosing conditions is not part of the massage therapy scope of practice.

Initial _____

I am aware of, and agree to, the fee schedule as presented by Natural Path Wellness Ltd. online and in the clinic.

Initial _____

In the event that I miss an appointment or fail to give 24 hours notice to cancel an appointment, I agree to pay a missed appointment fee.
One Hour treatment $55 plus HST
PLEASE NOTE: Fees for missed appointments ARE NOT COVERED by any health provider and must be paid before your next appointment.

Initial _____

I am aware that from time to time Natural Path Wellness sends out birthday and reminder emails and may also request that I join a an email list. I will inform my therapist or another representative of NPW if I do not wish to be a part of this.

Initial _____

All information provided by you is strictly confidential and will not be released without written consent.
***You may verbally withdraw your consent at any time before or during treatment.**

Client's Signature _____

Date _____