# HEALTH HISTORY FORM

An accurate health history is important to ensure that it is safe for you to receive a massage treatment. All information gathered for this treatment is confidential except as required or allowed by law. Written authorization will be required for release of any information**.**
**24 hour cancellation notice is required otherwise a missed appointment fee will be charged. This form must be updated annually.**

---

**First Name:** _____ **Last Name:** _____
(this is how your name will appear on your receipt)

**Address:** _____ ***Preferred method of contact:*** **TEL. Bus ☐ Home ☐ Cell ☐ Email ☐**

**City:** _____ **Province:** _____ **Tel. Bus/Home:** _____

**Postal Code:** _____ **Date of Birth:** _MM/_DD/_YY **Tel. Cell:**_____

***Please specify*: M ☐ F ☐ Other ☐** _____ **Email:** _____

**Do you have a Primary Health Care Physician? ❑ Yes ❑ No**
**Name of PHCP:** _____
**Address of PHCP:** _____
**Tel No. of PHCP:** _____
**Emergency Contact Person:** _____

**Were you referred by another Health Practitioner? ❑ Yes ❑ No**
**Name of HP:** _____
**Address of HP:** _____
**❑ Other Referral:** _____
**Emergency Contact Person Tel:**_____

**1st Massage Therapy: Yes ☐ No ☐ General Health Status:** _____ **Primary Complaint:** _____

**How did you first hear about Blue Vision Wellness?** _____ **Occupation:** _____

Health History: Please indicate ☑ conditions you are experiencing, present or past.

**Soft Tissue/Joints**
(Specify its nature: Pain, Stiffness, Numbness, Twitching, etc.)

| | Present | Past |
|---|---|---|
| ❑ neck | _____ | _____ |
| ❑ shoulder | _____ | _____ |
| ❑ upper back | _____ | _____ |
| ❑ mid back | _____ | _____ |
| ❑ low back | _____ | _____ |
| ❑ arms | _____ | _____ |
| ❑ chest | _____ | _____ |
| ❑ legs | _____ | _____ |
| ❑ knees | _____ | _____ |
| ❑ hips | _____ | _____ |
| ❑ other | _____ | _____ |

**History Headaches**
- ❑ tension
- ❑ migraines
- ❑ tooth/jaw/ear pain
- ❑ head trauma/date: _____
- ❑ history of headaches/type: _____
- ❑ other: _____

**Mental Health**
- ❑ depression
- ❑ anxiety
- ❑ PTSD
- ❑ other (phobias, manic, etc.) _____

_____
- ❑ family history of any of the above

**Smoker: ❑**

**Respiratory**
- ☐ chronic cough
- ☐ shortness of breath
- ☐ bronchitis
- ☐ asthma
- ☐ emphysema
- ☐ pneumonia
- ☐ sinus problems
- ☐ family history of any of the above

**Cardiovascular**
- ☐ high blood pressure
- ☐ low blood pressure
- ☐ heart attack (date:_____ )
- ☐ phlebitis / DVT
- ☐ stroke / CVA (date:_____ )
- ☐ pulmonary emboli
- ☐ pacemaker
- ☐ heart disease
- ☐ angina
- ☐ chronic congestive heart failure
- ☐ family history of any of the above

**Infectious Disease**
- ☐ hepatitis
- ☐ infections skin conditions
- ☐ tuberculosis
- ☐ HIV
- ☐ other: _____

**Gastroinstestinal**
- ☐ irritable bowel syndrome
- ☐ colitis
- ☐ gastroenteritis
- ☐ Crohn's disease
- ☐ constipation
- ☐ family history of any of the above

**Skin**
- ☐ skin condition
  specify _____
- ☐ bruise easily
- ☐ herpes
- ☐ varicose veins
- ☐ athletes foot
- ☐ loss of sensation

**Other Conditions**
- ☐ neurological conditions _____
- ☐ epilepsy
- ☐ diabetes/onset: _____
- ☐ allergies: _____
  (❑ anaphylaxis; ❑ skin irritations)
- ☐ family history of allergies
- ☐ family history of hypersensitivities
- ☐ cancer _____
- ☐ arthritis _____
  type OA/RA/other: _____
  where _____
- ☐ family history of arthritis
- ☐ vision loss
- ☐ hearing loss
- ☐ insomnia
- ☐ haemophilia
- ☐ kidney/bladder problems
  (❑ dialysis)
- ☐ overactive bladder
- ☐ osteopenia
- ☐ osteoporosis
- ☐ positional vertigo
- ☐ family history of any of the above
- ☐ other: _____

**Please continue on the next page…**

**Women**

- ❑ pregnant / due date: _MM_/_DD_/_YY_
- ❑ gynecological conditions: _____
- ❑ breast pain
  - cysts
  - breast lift (date): _MM_/_DD_/_YY_
  - breast augmentation (date): _MM_/_DD_/_YY_
  - breast reduction (date): _MM_/_DD_/_YY_
- ❑ menopause
- ❑ hysterectomy (date): _MM_/_DD_/_YY_

**ACCIDENT/INJURY**

❑ Car Accident ❑ Work Related ❑ Other

Date: _____

Symptoms: _____

_____

Physical Limitations: _____

_____

_____

**Surgery**

type _____

date: _MM_/_DD_/_YY_

current symptoms _____

_____

_____

**Current Medications and Conditions**

_____

_____

_____

❑ **Present involvement in other Health Care: Yes/No**
If Yes, specify: _____

❑ **Pins / Wires / Prosthetics:** _____

❑ **Medical Alert Bracelet** (specify condition / allergy)

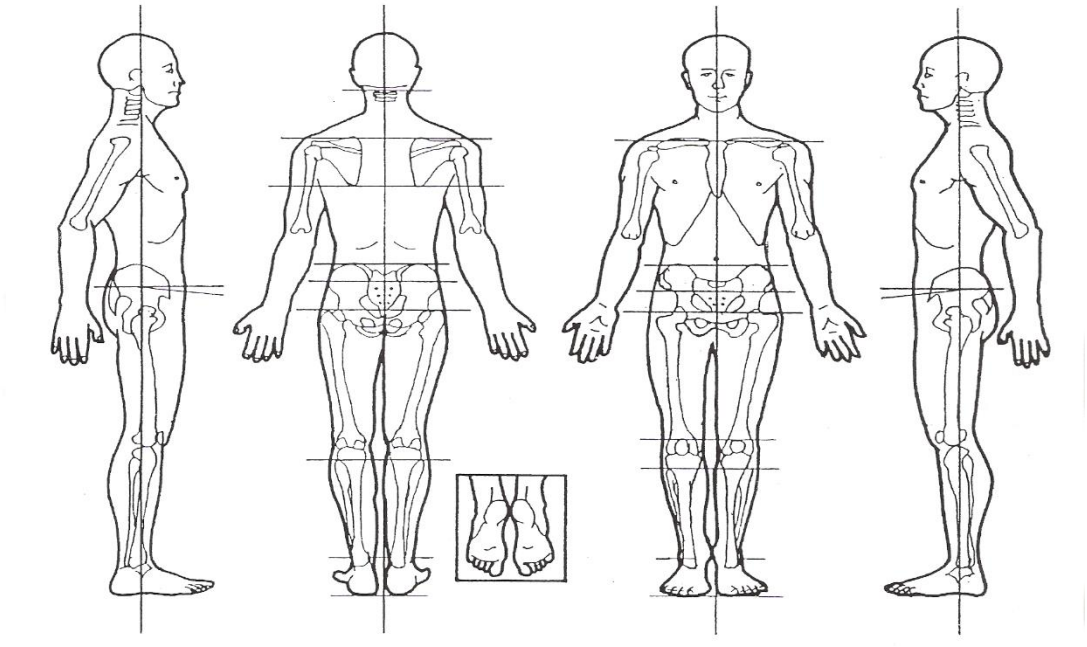
_____

_____

I have read the above information and have stated all my previous and current medical conditions. I take it upon myself to update the massage therapist regarding any changes in my condition. I understand that all massage treatments will be discussed and planned with the massage therapist, and will require my informed consent. **I understand the 24 hour cancellation policy and agree to pay the missed appointment fee if I cancel within the 24 hour period preceding my appointment time. I understand Blue Vision Wellness' lateness policy that I am responsible to pay for the time I reserved with the therapist, regardless of the time I arrive and I am ready for my appointment**.

**Signature:** _____ **Date:** _____

**(Chart for therapist's use only)**



**UPDATED**

**Date:** _____ **Client Signature:** _____

**Date:** _____ **Client Signature:** _____

**Date:** _____ **Client Signature:** _____

# RELEASE OF INFORMATION TO INSURANCE COMPANIES

Due to the online submitting of insurance claims, insurance companies are randomly selecting clients and calling the clinics they attend to verify appointment dates and amounts. Under privacy rules and regulations, Blue Vision Wellness is not permitted to divulge any information without a release form completed and signed by our clients. As a client of this practice, we are concerned that delays in confirming this information will result in a delay of you receiving your reimbursement cheque. Please complete and sign the applicable portion of the form below for us to confirm "only" your dates and amounts to the insurance companies requesting this information. No other information will be released unless we receive a signed consent form requesting additional information. This signed release form will remain with your file.

---

**Client Information**:

Last name _____ First name _____ Initials _____

Address _____

Telephone number _____ Date of birth _____

**Substitute Decision Maker Contact Information:**
*Please include copies of documents to substantiate authority as a substitute decision maker.*

Last name _____ First name _____ Initials _____

Address _____

Telephone number _____ Relationship to the Client _____

---

I _____, hereby authorize Blue Vision Wellness to release "only" the date(s) and amount(s) of my treatment(s) to insurance companies' inquiries regarding my attendance at Blue Vision Wellness Inc.

Signature of Client/
Substitute Decision Maker: _____ Date: _____

# PRIVACY POLICY

Your knowledge and consent are required before we may collect, use, or disclose your personal information except in rare circumstances (i.e. subpoena, medical emergency, and debt collection). If you have a question on any of this, please ask our receptionist.

## *Email Notification*

I understand that only if I check off the following boxes will I receive an email from Sheri Robinson or Blue Vision Wellness; and that I have an option to be taken off the email list at any time by sending an email to bluevisionwellness@gmail.com should I choose not to receive future emails from Blue Vision Wellness.

- ☐ Confirmation of appointment
- ☐ Email reminder to book an appointment **(monthly basis)**
- ☐ Email Contact **(Re: cancellations, appointment availabilities, etc.)**
- ☐ Advertising, Promotions, & Research **(E.g. sidewalk sale or booths with free in-chair massage, handouts or draws for massage gift certificates, massage presentations, & opportunities to participate in research)**

**Email:** _____

# GENERAL POLICIES

## *Massage Treatment Entails*

Assessment, reviewing the health history form with your therapist, massage and self-care advice at the end of the treatment.

## *First Visit*

Your RMT will review your Health History form with you and will ask you questions to ensure that you receive a treatment that meets your needs. You will be asked to update this form yearly for address changes and any health related changes that your Registered Massage Therapist (RMT) should be aware of.

## *Illness*

**If you have a fever or a cough related to flu or cold symptoms please call and reschedule your appointment. Massage is contraindicated for fevers and can exacerbate flu-like symptoms. Please leave a message for your therapist if you need advice.**

**Please Initial:** _____

### *Cell Phones*

We ask that you do not make or receive phone calls on portable devices while in the clinic.

## LATENESS POLICY

Clients are responsible for the time they reserve for their appointment. If you are late for your appointment the treatment will still end at the designated time with no change in fee.

## CANCELLATION POLICY

Blue Vision Wellness has a cancellation policy, when you book an appointment with a therapist you are booking that therapist's time. In order to accommodate all our clientele we need 24 hours' notice of cancellation and/or rescheduling, less than that is inadequate time for us to offer your appointment time to others. If you are unable to make it we request that you call 24 hours in advance. If you do not call to cancel and/or reschedule before the 24 hour period a cancellation fee will be charged.

Cancellation fees are ~50% of treatment fees, and subject to change with notice. 100% of the cancellation fee is given to the massage therapist.

***If you book within the 24 hour time frame, the policy is in effect immediately.****

**I have read, understood, and agreed to both pages one and two of this policies document. Including:**

- ***Privacy Policy*** **– I consent to the collection, use, or disclosure of my information as described in Blue Vision Wellness' client Privacy Policy.**
- ***Cancellation Policy*** **– I agree to pay the cancellation fee if I cancel or reschedule within the 24 hours preceding my appointment time.**
- ***Lateness Policy*** **– I agree to pay for the full time I reserved with the therapist even if the treatment length is decreased because I arrived late for my appointment.**

**Signature:** _____ **Date:** _____

***Thank you for your consideration and cooperation.***

If you have any questions about Blue Vision Wellness Policies, please do not hesitate to ask our receptionist. If you have any questions about massage therapy your Registered Massage Therapist will be pleased to answer them. Massage treatments by a Registered Massage Therapist may be covered under your insurance plan, ask your plan coordinator if you are eligible for reimbursement.