Dale Blacker, RMT at Insight Naturopathic – 550 Eglinton Ave. E.
Please read the following thoroughly and sign where appropriate.

Please note: Please be as detailed as possible. A detailed health history helps me develop a clear picture of your overall health, so that I can provide the best care possible. All information gathered is confidential and will not be disclosed to anyone without your express written consent.

Name:_____

Address:_____

_____

_____

Postal Code:_____

Phone Numbers (Please list at least one)

Home:_____

Cell:_____

Business:_____

Email:_____

Date of birth:_____

Family doctor:_____

Their contact information:

_____

_____

_____

_____

_____

Date:_____

(please initial)_____

Annual update 1:_____

Annual update 2:_____

Annual update 3:_____

Annual update 4:_____

How did you hear about us?

_____

_____

If referred by a health care professional, please provide their name and address:

_____

_____

_____

Have you had a massage before? Y N

How long since your last?

_____

_____

Occupation:

_____

How many hours a day do you spend:

Phone:_____

Computer:_____

Driving:_____

Lifting:_____

Sports/Recreation:

Type:_____

_____

Hours per week:_____

Intensity : low medium high

Level: amateur casual hobbyist elite professional teacher

Motor Vehicle Accident:

Date(s):_____

_____

What treatment did you receive?

_____

_____

Do you still have any problems?

_____

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Please read the following thoroughly and sign where appropriate.

Please indicate conditions you are experiencing or have experienced. Relevant details include location on your body, any surgeries, and anything else that may be relevant.

Condition:	Past √	Current √	Family History (y/n/u)	**Relevant details** (please include any surgery and/or prescriptions):
Cardiovascular:				
High blood pressure				
Low blood pressure				
C.C.H.F.				
Phlebitis/varicose veins				
Pacemaker or similar				
D.V.T.				
Stroke				
Other				
Respiratory:				
Chronic cough				
Shortness of breath				
Bronchitis				
Asthma				
Emphysema				
Other				
Infections:				
Hepatitis (a b c)				
TB				
HIV				
Other				
Autoimmune:				
Lupus				
Chronic fatigue				
Fibromyalgia				
Rheumatoid Arthritis				
Other				
Skin Conditions:				
Dermatitis				
Athletes foot				
Eczema				
Other				

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Please read the following thoroughly and sign where appropriate.

Intestinal:				
Ulcer				
Crones				
U.C.				
I.B.S.				
Other				
Mental:				
Depression				
Anxiety				
Bipolar				
ADD/ADHD				
Other				
Misc:				
Diabetes (I II)				
Neuralgia				
Cancer				
Epilepsy				
Osteoarthritis				
Allergies				
Other				

Other Surgery (please list with dates and include any pins, screws or jt. replacement):

_____

_____

_____

Pregnancy (due date and any complications):

_____

_____

Ongoing medical care (chiro, physio, etc):

_____

_____

Please estimate your overall health: _____

What brings you here today?

_____

_____

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Privacy Statement

Attached to this document is a New Patient Health History Form. In order to ensure the best care possible, I'd like you to spend a few minutes helping me build a health profile for you. An accurate picture will allow me to recommend an ideal treatment approach and minimize the risk of potential complications. I'll be recording the details of each treatment you have with me.

All information I collect is private and confidential, and will not be shared without your express written consent. Paper and electronic files will be stored securely and destroyed when appropriate.

You are entitled to access to your health file at any time. As such, accurate contact information will allow me to contact you in case of a change to my practice (and the location of your file). If you've provided an email address, I may send periodic messages to update you with news about the clinic and my practice. This will never be done by a third party and please know that if you don't want to receive these emails, just reply with a request, and I'll remove you from my active contact list.

Informed Consent

Massage treatments may only be applied with your participation and consent. Before each treatment, we will asses your current situation and discuss your goals for the session. We can modify your experience as your needs change, even during the massage. Please ask questions as they occur to you. I will check in frequently to ensure your comfort.

While it is traditional (and more relaxing) to undress down to your underwear, it isn't necessary. We can modify treatment to work through clothes. While you're getting ready for your massage, I'll be out of the room and will only return when you've acknowledged that you're ready. I'll only be uncovering the area I'm working on at the time and I can work through the sheets when necessary.

Fees are due after treatment at the posted rate unless other arrangements have been made in advance. Please try to notify me the day before a scheduled session of any need to cancel or reschedule. Last minute changes may incur a cancellation fee as posted on the fee schedule.

Your signature below is an acknowledgement that you have read and understood everything above. Consent for further treatment sessions is implied unless there's an indication of change in the ability to understand and give consent. You can withdraw consent at any time.

Name (please print) _____ Signature: _____ Date:_____

Substitute Decision Maker:

Please write the patient's name above. By signing for them, you acknowledge that you feel the patient can benefit from massage therapy and that their needs and privacy will be maintained.

Name (please print) _____ Signature: _____ Date:_____

Phone: _____ Email:_____