OV MOBILE MASSAGE: **HEALTH HISTORY**

Date: ______________________

Name: ____ ***Date of Birth (yyyy-mm-dd):*** ______________________

Phone: Home: __________________________ Cell: _____________________ Work: ___________________________

Home Address: ________________________________ City: ______________________Postal Code: _______________

Email Address: ____

Family Physician: ________________________Physician contact number: ______________________________

Occupation:_____________________________ (stand / sit / labour)

Whom may OV Mobile Massage thank for referring you? ____

What is your presenting complaint? Where do you feel the problem?

____

When did it start? ________________________ How did it start? ____

What aggravates your condition?____

Have you had this or a similar condition before? □Yes □No If yes, then when?_____________________________

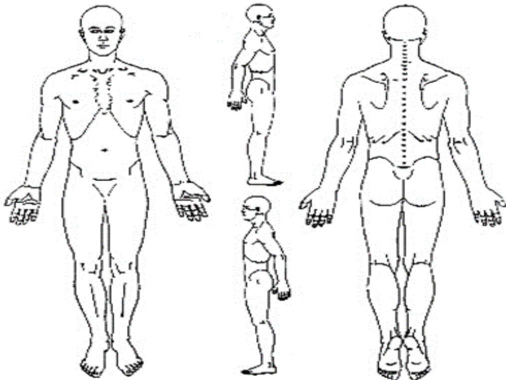
How would you rate your pain on average? (0 = no pain, 10 = worst pain)

0 1 2 3 4 5 6 7 8 9 10

How frequent is your problem? □Constant (76-100%) □Frequent (51-75%) □Occasional (26-50%) □Comes & Goes

Do you feel your condition is getting: □Better □Worse □No Change

Mark an "X" or circle on the picture where you currently have symptoms (Example: Pain, numbness, tingling)



Have you been given a diagnosis for your current condition? (Example: Rotator cuff tear)

____

Have you seen a physiotherapist/chiropractor/massage therapist/doctor for this or a similar condition? □Yes □No

If yes, name of practitioner? ______________________________

Location?____

Have you had MASSAGE THERAPY services before performed by a *registered massage therapist?* (Y / N)

Preferred techniques: □Swedish massage □Deep Tissue □Scar □Sports massage □Active Release Technique (ART)

□Trigger Point work □Stretching □Relaxation/Spa □Other ____

Patient-Specific Functional Scale

Identify 3 to 5 important activities that you are unable to do or are having difficulties with as a result of your injury.

0 1 2 3 4 5 6 7 8 9 10

Unable to perform *Able to perform at same level before injury*

Activity *(example: putting on shoes, carrying groceries, vacuuming, prolonged sitting, sleeping)*	Score (0-10)
1.	
2.	
3.	
4.	
5.	

CONTINUED ON REVERSE

Pain Description
- ☐ Joint pain/stiffness in the morning >2 hours
- ☐ Walking problems
- ☐ Balance problems
- ☐ Night pain
- ☐ Unexplained weight loss

Cardio/Vascular
- ☐ Chest pain
- ☐ Shortness of breath
- ☐ Blood pressure (high/low)
- ☐ Irregular heartbeat
- ☐ Heart problems
- ☐ Varicose veins
- ☐ Ankle swelling
- ☐ Stroke
- ☐ Thyroid (hyper/hypo)
- ☐ Asthma
- ☐ Diabetes (Type I / Type II)
    - Date:_____________

Head/Neck
- ☐ Headaches / Migraines
- ☐ Dental work: _____________
- ☐ Vision problems
- ☐ Ear problems / Hearing loss
- ☐ Concussion
    - Date:_____________

Gastrointestinal
- ☐ Excessive thirst
- ☐ Frequent nausea
- ☐ Vomiting
- ☐ Diarrhea
- ☐ Constipation
- ☐ Blood in stool

Infections
- ☐ Hepatitis
- ☐ Skin conditions: ____________
- ☐ Tuberculosis
- ☐ HIV
- ☐ Herpes

Females
- ☐ Pregnancy
    - Due date:_________
- ☐ Recent delivery?
    - Date:_____________
- ☐ Menstrual Problems
- ☐ Breast pain/lumps

Motor Vehicle Accident
- ☐ Date of Accident:____________
- ☐ Loss of consciousness? (Y / N)
- ☐ Airbags deployed? (Y / N)
- ☐ Seatbelts worn? (Y / N)
- ☐ Type of collision: ____________

Mental Health
- ☐ Depression
- ☐ Anxiety
- ☐ PTSD
- ☐ Other: ____________________

Other relevant conditions (ie pacemaker, IBS, osteoporosis, etc)

____

____

Surgeries – date and nature:

____

____

Do you have any pins/wires/surgical implants? (Y / N): ____

Current Medications/Vitamins/Herbs/Supplements:

____

____

____

____

Last physical exam date: ___________________________________

Results: ____

Has anyone in your family had heart disease, stroke, or cancer? (Y / N)

If yes, specify: ____

IN CASE OF EMERGENCY CONTACT:
NAME: ____ **RELATIONSHIP:** __________________________________
PHONE: ____

PATIENT SIGNATURE: ____
PARENT/GUARDIAN SIGNATURE: ____

OV MOBILE MASSAGE: **PATIENT POLICY FORM**

- **CELL PHONES**: Please remember to turn off or set your cell phones to vibrate while you are in treatment.

- **BE READY**: Being able to give you the care you need means Wesley Gresham, RMT needs to see you for the entire duration of your appointment. This means having an area easily accessible for set-up 10-15 minutes prior to your treatment.

- **LATE / MISSED Appointments:** If you should happen to be late for your appointment, Wesley Gresham, RMT will still be able to treat you for the duration of the scheduled time. However, the full appointment fee will still apply. If you miss an appointment, Wesley Gresham, RMT will be happy to try and find an alternate time slot for you for the same day if possible**.** Wesley Gresham, RMT will charge a missed appointment fee for the **FULL FEE** should you be unable reschedule your appointment within the same day. Missed appointments do not allow the massage therapist to fill the appointment spot in time resulting in loss of income.

  ___________ Initial please

- **CANCELLED Appointments**: **Less than 24-HOUR notice of cancellation** will result in a charge of the **FULL FEE** for massage therapy**.** This fee will be invoiced to your account. Please note that insurance companies do not cover missed/cancelled appointment fees under any circumstances. Cancelled appointments within 24 hours do not allow the massage therapist to fill the appointment spot in time resulting in a loss of income.

  ___________ Initial please

- **PAYMENT:** All services are to be paid for upon completion of the treatment, **including** massage therapy services for motor vehicle accident injuries as per OV Mobile Massage's policies. For more information, please refer to www.ovmobilemassage.weebly.com**.**

  ___________ Initial please

- **PERSONAL INFORMATION**: Please advise OV Mobile Massage of any changes to your personal information (address, work/home/cell numbers, email address)

- **PRIVACY STATEMENT:** Any and all of the personal health information you provide to OV Mobile Massage is kept in total privacy and confidence without exception. Wesley Gresham, RMT may ask for your permission to disclose treatment plans to other involved health care practitioners for the purpose of furthering your care. Your express written consent (electronic or hard copy) is required for all third party individuals requesting to access your information. For more information, please refer to www.ovmobilemassage.weebly.com.

By initialing and signing, I acknowledge I understand OV Mobile Massage's patient policies and agree to abide by these policies.

______________________________________ ______________________

Patient Signature Date

OV MOBILE MASSAGE: **SENSITIVE AREA INFORMED CONSENT**

Following a discussion and review of assessment findings, I,__________________________________(client name), have requested treatment by Wesley Gresham, RMT for treatment of the areas identified below, for the purposes of treating the following clinical indications:

By initialing, I am aware that Wesley Gresham, RMT will touch the following area(s) of my body as part of my therapeutic treatment **(no checkmarks, initials ONLY).**

	Date	**Date**	**Date**	**Date**	**Date**	**Date**	**Date**	**Date**
Region								
Breast(s)								
Chest Wall Muscles								
Inner Thigh(s)								
Buttocks (gluteal muscles) (supplied once per treatment plan is suffice. Verbal is required only for follow up treatment)								

By initialing, I confirm that Wesley Gresham, RMT has received ***informed consent*** and I fully understand the proposed treatment. Informed consent includes the nature of the assessment, including the clinical reason(s) for treatment of the above area(s) as detailed below.

The expected benefits of the treatment								
Initials (for date in column)								
The potential risks of the treatment								
Initials (for date in column)								
The potential side effects of the treatment								
Initials (for date in column)								
Alternative courses of action								
Initials (for date in column)								
Likely consequence of not having the treatment								
Initials (for date in column)								
Consent for today’s treatment is voluntary								
Initials (for date in column)								
That I can withdraw or alter my consent at any time								
Initials (for date in column)								

The client has the right, at any time, to remove any of the consent applied above with a verbal indication. Signature below will be considered valid, and updated, for each date(s) listed, as long as the initials were supplied on said date.

Client Name (print): ________________________________ Date (initial Ax): ______________________________

Client Signature: __________________________________

RMT Signature: ____________________________________

Wesley Gresham, RMT S454