Esprit Wellness Centre - Health History Form

First Name:	Last Name:
Address:	City: Province:
Postal Code: Date of Birth: MM/DD/YY	Email:
Phone (Home):	Phone (Cell):
Phone (Bus):	Emergency contact person:
Do you have a primary health care physician? Yes No	Emergency contact phone:
Physicians name:	Primary Complaint:
Physicians address:	
Physicians phone:	How long?
Is this your first massage therapy treatment? Yes No	General Health Status:
Insurance Information	
Primary insurance company:	Ins. number(plan/group/ID):
Coverage: % to $ /yr Deductible:	DR RX required? Yes No Date: MM/DD/YY
Secondary insurance company:	Ins. number(plan/ID/contract/group):
Coverage: % to $ /yr Deductible:	DR RX required? Yes No Date: MM/DD/YY
Name of Cardholder:	Date of Birth: MM/DD/YY Employer:

Cancellation Policy: Amid the uncertainty of COVID-19, we have modified our cancellation policy. If you are feeling unwell for any reason, for your health and the health of others at our clinic, you are asked to reschedule your appointment. Our cancellation fee will be waived in the event that you are ill. We hope this will alleviate any hesitation you have about an upcoming appointment. 24-hour cancellation is still required for all other reasons. Any cancellations that occur after scheduled time of treatment or any no show appointments will be required to pay the full fee of appointment.

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

CARDIOVASCULAR	**GASTROINTESTINAL**
❏ High/low blood pressure	❏ Irritable bowel syndrome
❏ Heart attack | Date: M/DD/YY	❏ Colitis
❏ Phlebitis/DVT	❏ Gastroenteritis
❏ Stroke/CVA | Date: MM/DD/YY	❏ Crohn's disease
❏ Pulmonary emboli	❏ Constipation/Bloating
❏ Pacemaker	**HEADACHES HISTORY**
❏ Heart disease	❏ Tension / Migraines
❏ Angina	❏ Tooth/Jaw/Ear pain
❏ Varicose veins	❏ Head trauma | Date:
❏ Chronic congestive heart failure	❏ History of headaches | type:
❏ Family history of any of the above	
❏ Smoker	❏ Other:

SOFT TISSUE/JOINTS/BONES
Specify if: pain,stiffness,numbness,twitching ect.

	Present	Past
Neck	❏	❏
Shoulder	❏	❏
Upper Back	❏	❏
Mid Back	❏	❏
Low Back	❏	❏
Arms	❏	❏
Chest	❏	❏
Legs	❏	❏
Knees	❏	❏
Hips/Other	❏	❏
Fractures	❏	❏
Arthritis	❏	❏

ACCIDENT/INJURY	INFECTIOUS DISEASE	SKIN
❏ Car accident	❏ Hepatitis	❏ Skin condition | Type:
❏ Work -related Date::M/DD/YY	❏ Infections/skin conditions	❏ Bruise easily
❏ Symptoms:	❏ Tuberculosis	❏ Athletes foot
	❏ HIV	❏ Loss of sensation
	❏ Other:	
WOMEN	**OTHER CONDITIONS**	
❏ Pregnant | due date:MM/DD/YY	❏ Neurological conditions	❏ Haemophilia
❏ Gynecological condition(s):	❏ Epilepsy	❏ Kidney/Bladder problems
	❏ Diabetes | onset:	❏ Dialysis
	❏ Allergies | Type:	❏ Overactive bladder
	❏ Cancer | type:	❏ Osteoporosis
RESPIRATORY	❏ Family history of arthritis	❏ Positional Vertigo
❏ Chronic cough	❏ Vision loss	❏ Mental health disorder
❏ Shortness of breath	❏ Hearing loss	❏ Other:
❏ Bronchitis	❏ Insomnia	Stress level 1-10:
❏ Asthma	**SURGERY**	
❏ Emphysema	Type:	
❏ Pneumonia		Current symptoms:
❏ Sinus problems		
	Date: MM/DD/YY	
❏ Pins/wires/prosthetics		
❏ Medical alert bracelet |specify condition or allergy:	❏ Present involvement in other health care. If yes, specify:	

CURRENT MEDICATIONS & CONDITIONS

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I, the undersigned, have read and understand the following. The personal information herein as well as any other personal information currently held or collected in the future by the Therapists of Esprit Wellness Centre, may be disclosed to other members of the medical profession if the attending therapist feels it will be beneficial to the clients overall condition. I understand my information will be kept confidential and secure. My information will be released only with my written consent. It is my responsibility to keep the massage therapist updated on my medical history. I consent to be assessed by my massage therapist, using a variety of examinations and techniques, for the conditions noted on my health history. I have had the opportunity to ask questions about my massage therapy assessment, and understand I may withdraw my consent at any time. I understand that Esprit Wellness Centre is not held responsible to any adverse effects for the treatment provided, or held responsible for any injury that may occur on the premises or while receiving treatment.

Patient Name (Please print):____ Date:______________

Patient Signature (or signature of parent.guardian):______________________________ Date:______________

Esprit Wellness Centre COVID-19 Disclosure Form

Based on the available information as of this date ________________ provided by the Province of Manitoba, the Government of Canada, and the Massage Therapy Association of Manitoba, the best course of action to prevent the spread of COVID-19 is to practice physical distancing, social quarantine and self-isolate and self-monitor as needed.

I understand that I must disclose if I:

1. Have one or more of the below symptoms: Fever, cough, sore throat, shortness of breath/breathing difficulties o Other symptoms such as muscle aches, fatigue, loss of smell or taste, headache, runny nose, hoarse voice, nausea, vomiting or diarrhea

2. Have travelled outside of Manitoba in the last 14 days

3. Have had close contact (face-to-face contact within 2 meters/6 feet) with someone who is ill with cough and/or fever who has travelled outside of Manitoba within 14 days prior to their illness onset (contact may be in Canada or during travel)

4. Have been in contact in the last 14 days with someone who is confirmed to be a case of COVID-19 5. Have had laboratory exposure while working directly with specimens known to contain COVID-19

I, ___________________________, have been made aware of the above-mentioned recommendation and have disclosed all information as requested above to the best of my ability. I have read, and have had an opportunity to discuss the risks and benefits of proceeding with massage therapy treatment with my RMT.
I understand that despite the RMT's best efforts to take appropriate precautions, that there is a possibility that I could come in contact with the COVID-19 virus during the course of my massage therapy treatment.

I agree that _________________________________, will not be held responsible or liable of any COVID-19 related injuries or illnesses which include but are not restricted to acute or chronic respiratory, cardiovascular, immune system conditions and/or death as a result of this from this or future massage therapy treatments provided by _________________________________.

Signed: __________________________________ Date: ______________________________

(RMT): __________________________________ Date: ______________________________