MASSAGE THERAPY CONFIDENTIAL
PATIENT CASE HISTORY FORM

Please take a moment to fill out this confidential health history form. This will ensure that you receive proper treatment and that it is safe for you to do so. Thank you.

Name (please print): ______________________________ **Date:** ____________________

Address: ______________________________ **City:** ____________ **Postal Code:** ____________

Phone: Home ____________________ **Business** ____________________ **Cell:** ____________________

Date of Birth: ____________________ **Sex: M F**

Occupation: ____________________ **Regular hobbies/sports/activities:** ____________________

Physician name/address/phone: ____

Current Medications (including non-prescription): ____
____

Have you recently been in a vehicle accident/work related injury to which you will be making claim? YES NO

Allergies? ____

Who referred you to this clinic? ____

When did your symptoms begin? ____

Have they changed & how? ____

Is this condition interfering with: WORK SLEEP DAILY ROUTINE ACTIVITIES

Please explain: ____
____

Have you seen any other health care practitioner concerning this complaint? Medical dr. ☐ Chiropractor ☐

Physiotherapist ☐ Massage Therapist ☐ Other ______________________________

Have they provided results? ____

Surgery/injuries/hospitalization: (date, past & current symptoms) ______________________________
____

Do you have any internal pins/wires/artificial joints? ______________________________

Please check all that apply.

HEAD/NECK

- [ ] Headache
- [ ] Migraine
- [ ] Visual Disturbances
- [ ] Contact lenses/glasses
- [ ] Earaches
- [ ] Hearing Problems
- [ ] Jaw Pain/Dental Problems
- [ ] Whiplash

DIGESTIVE/URINARY

- [ ] Difficult Digestion
- [ ] Constipation
- [ ] Liver/Gallbladder
- [ ] Kidney/Urinary
- [ ] Diabetes (Type & Onset)
- [ ] Hypoglycaemia
- [ ] Crohn’s disease
- [ ] Irritable bowel
- [ ] Ulcers

MUSCLE/JOINTS

- [ ] Neck
- [ ] Low back
- [ ] Mid back
- [ ] Upper back
- [ ] Shoulder
- [ ] Hip
- [ ] Knee
- [ ] Ankle

Other ______________________________

CARDIOVASCULAR

- [ ] High blood pressure
- [ ] Low blood pressure
- [ ] Chronic Congestive
- [ ] Heart Failure
- [ ] Poor circulation
- [ ] Heart disease
- [ ] Phlebitis
- [ ] Varicose Veins
- [ ] Stroke
- [ ] Heart Attack
- [ ] Pacemaker
- [ ] Arteriosclerosis
- [ ] Irregular heart beat

SKIN

- [ ] Bruise easily
- [ ] Eczema
- [ ] Psoriasis
- [ ] Sensitivity
- [ ] Skin condition

(please specify)

____

- [ ] Loss of sensation

(describe)

RESPIRATORY

- [ ] Asthma
- [ ] Chronic cough
- [ ] Shortness of breath
- [ ] Bronchitis
- [ ] Smoker
- [ ] Emphysema

FEMALE

- [ ] Menstrual problems
- [ ] Pregnancy

Due date: ___________________

- [ ] Menopausal problems
- [ ] Gynaecological conditions

OTHER

- [ ] Hemophiliac
- [ ] Epilepsy

How is your general health?____

Additional information: ____

____

This is to certify and acknowledge that the above-mentioned information is correct and accurate to my knowledge and that I give consent for my treatment by a Registered Massage Therapist. I also acknowledge the policy that appointments cancelled with less than 24 hour notice or missed will be subject to a 50% charge of the scheduled appointment time.

Signature: ______________________________ **Date:** ______________________________

Email: ______________________________