

# 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: Day/Month/Year Sex: M F Height & Weight: \_\_\_\_\_

Occupation: \_\_\_\_\_ Regular hobbies/sports/activities: \_\_\_\_\_

Physician name/address/phone: \_\_\_\_\_

Current Medications (including nonprescription): \_\_\_\_\_

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

Allergies? \_\_\_\_\_

Who referred you to this clinic? \_\_\_\_\_

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What is your primary complaint? \_\_\_\_\_

Can you describe it? DULL SHARP SHOOTING ACHY NUMB TINGLING STIFF

Pain scale: (low) 1-----5-----10 (high) Does it radiate anywhere? \_\_\_\_\_

Does anything aggravate your symptoms? \_\_\_\_\_

Does anything relieve your symptoms? \_\_\_\_\_

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)
- Hypoglycemia
- 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) \_\_\_\_\_
- Athlete's foot
- Cold sores
- Plantar warts

**FEMALE**

- Menstrual problems
- Pregnancy
- Due date: \_\_\_\_\_
- Menopausal problems
- Gynaecological conditions

**OTHER**

- Hemophiliac
- Epilepsy
- Cancer
- Location \_\_\_\_\_
- Arthritis OA  RA
- Family history \_\_\_\_\_
- Fibromyalgia
- Osteoporosis
- Chronic fatigue syndrome
- Scoliosis
- Carpal tunnel syndrome
- Fainting/dizziness/loss of consciousness
- Hernia

**RESPIRATORY**

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

**INFECTIOUS CONDITIONS**

- Tuberculosis Y N
- AIDA/HIV Y N
- Hepatitis Y N
- Type \_\_\_\_\_
- Infectious skin condition(s) Y N

How is your general health? \_\_\_\_\_

Additional Information: \_\_\_\_\_

This is to confirm 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 \$25.00 charge.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Email: \_\_\_\_\_