

Update 1 _____
 Update 2 _____

Confidential Patient Case History Form

Please print clearly

Date _____

Name _____ Male Female

Address _____ City _____ Prov _____

Postal Code _____ Home Phone: _____ Work Phone: _____

Birth Date: _____(m) _____(d) _____(y) Occupation: _____

Medical Doctor: _____ Doctor Phone #: _____

How did you hear about us? _____

Please indicate conditions you are experiencing or have experienced:

<p><u>Cardiovascular</u></p> <p><input type="checkbox"/> High blood pressure <input type="checkbox"/> Low blood pressure <input type="checkbox"/> Chronic congestive heart failure <input type="checkbox"/> Heart attack <input type="checkbox"/> Phlebitis / varicose veins <input type="checkbox"/> Stroke / CVA <input type="checkbox"/> Pacemaker or similar device <input type="checkbox"/> Heart disease <input type="checkbox"/> Dizziness / vertigo <input type="checkbox"/> Seizures</p> <p><i>Is there a family history of any of the above?</i> <input type="checkbox"/> Yes <input type="checkbox"/> No</p>	<p><u>Respiratory</u></p> <p><input type="checkbox"/> Asthma <input type="checkbox"/> Bronchitis <input type="checkbox"/> Emphysema <input type="checkbox"/> Chronic Cough <input type="checkbox"/> Shortness of breath</p> <p><i>Is there a family history of any of the above?</i> <input type="checkbox"/> Yes <input type="checkbox"/> No</p>	<p><u>Digestive</u></p> <p><input type="checkbox"/> Constipation <input type="checkbox"/> Chrones Disease <input type="checkbox"/> Colitis <input type="checkbox"/> Irritable Bowel Syndrome <input type="checkbox"/> Ulcers</p>
<p><u>Head and Neck</u></p> <p><input type="checkbox"/> History of headaches <input type="checkbox"/> History of migraines <input type="checkbox"/> Vision problems <input type="checkbox"/> Vision loss <input type="checkbox"/> Ear problems <input type="checkbox"/> Hearing loss</p>	<p><u>Muscle/Joint</u></p> <p><input type="checkbox"/> Neck <input type="checkbox"/> Back (lower) <input type="checkbox"/> Back (mid) <input type="checkbox"/> Back (upper) <input type="checkbox"/> Shoulders <input type="checkbox"/> Elbow <input type="checkbox"/> Wrist / Hand <input type="checkbox"/> Hip <input type="checkbox"/> Knee <input type="checkbox"/> Ankle / Foot <input type="checkbox"/> Spine</p>	<p><u>Other</u></p> <p><input type="checkbox"/> Loss of sensation <i>Where?</i> _____ <input type="checkbox"/> Diabetes <i>Onset:</i> _____ <i>Type:</i> _____ <input type="checkbox"/> Allergies / hypersensitivity <i>What?</i> _____ <input type="checkbox"/> Epilepsy <input type="checkbox"/> Cancer <i>Type/Location:</i> _____ <input type="checkbox"/> Arthritis <i>Is there a family history of arthritis?</i> <input type="checkbox"/> Yes <input type="checkbox"/> No</p>
<p><u>Women</u></p> <p><input type="checkbox"/> Pregnancy <i>Due Date:</i> _____ <input type="checkbox"/> Previous pregnancy complications _____ _____ <input type="checkbox"/> Menopausal problems _____ <input type="checkbox"/> Menstrual problems _____ <input type="checkbox"/> Gynecological conditions <i>Describe:</i> _____</p>	<p><u>Infectious Conditions</u></p> <p><input type="checkbox"/> Skin Conditions <i>Describe:</i> _____ <input type="checkbox"/> Respiratory Conditions <i>Describe:</i> _____ <input type="checkbox"/> Hepatitis</p> <p><u>Skin Conditions</u></p> <p><input type="checkbox"/> Eczema <input type="checkbox"/> Psoriasis <input type="checkbox"/> Rash <input type="checkbox"/> Warts <input type="checkbox"/> Open Sores</p>	<p><u>Men</u></p> <p><input type="checkbox"/> Enlarged Prostate <input type="checkbox"/> Libido Issues <input type="checkbox"/> Other _____</p>

Do you have any medical conditions not listed above? Yes No

If yes, please describe: _____

Do you have any internal wires, artificial joints, pacemakers or special equipment that we should be aware of? Yes No

Please circle areas which are currently causing you symptoms of pain, stiffness, numbness or other forms of discomfort

Face	Upper back	Arm(s)	Hand(s)	Thigh(s)	Ankle(s)	Neck
Mid back	Elbow(s)	Finger(s)	Knee(s)	Feet	Shoulder(s)	Lower back
Wrist(s)	Hip(s)	Leg(s)	Toe(s)	Chest	Ribs	Tailbone

For what condition or reason are you seeking treatment today? _____

Have you seen any other health care professional(s) for this condition or reason? Yes No

If yes whom? _____

Have you ever been involved in any motor vehicle accidents? Yes No Date: _____

Have you been involved in any other accidents? Yes No Date: _____

Have you ever been knocked unconscious? Yes No Date: _____

Briefly list any surgeries you have undergone, for what and when.

Are you presently taking any prescribed medication(s)? Yes No

If yes, please list the medication(s) and the condition(s) for which it is being used if known.

Have you previously received massage therapy treatments? Yes No

If yes, were you treated: At this clinic From an RMT Other

Please circle on the following scales the extent to which you are currently satisfied with the following:

(5 represents total satisfaction, 1 represents little or no satisfaction)

Physical health & fitness	5	4	3	2	1
Mental & emotional happiness	5	4	3	2	1
Energy level	5	4	3	2	1
Diet	5	4	3	2	1
Ability to relax	5	4	3	2	1

I acknowledge that the Massage Therapist is not a physician and does not diagnose illness or disease or any other physical or mental disorder. I clearly understand that massage therapy is not a substitute for a medical examination. It is recommended that I attend my personal physician for any ailment that I may be experiencing. I acknowledge that no assurance or guarantee has been provided to me as to the results of the treatment.

I acknowledge and understand that the Massage Therapist must be fully aware of my existing medical conditions. I have completed my medical history form as provided by my Massage Therapist and disclosed all of those medical conditions affecting me. It is my responsibility to keep the Massage Therapist updated on my medical history. The information I have provided is true and complete to the best of my knowledge.

Signature

Date

Therapist Signature

Signature

Date

Therapist Signature

Signature

Date

Therapist Signature