CASE HISTORY FORM

Date: _____

PERSONAL DATA

Name: _____ Date of birth: _____

Address: _____

City: _____ Postal Code: _____

Telephone: Home: _____ Mobile: _____ Work: _____

Email: _____ Fax: _____

Occupation: _____

Referred by: _____

HEALTH INFORMATION

Primary care physician: _____ Telephone: _____

Address: _____

Prescription drugs?: ____yes ____no

If yes, please specify: _____

Condition it treats: _____

Non prescription drugs?: ____yes ____no

If yes, please specify: (ie tylenol, advil etc.) _____

Present involvement in other health care?: ____yes ____no

If yes, please specify: _____

_____

Surgery: _____ Date: _____

Please list presence of internal pins, wires, artificial joints or special equipment: _____

_____

_____

Have you ever received treatment from a registered massage therapist?: ____yes ____no

What is you primary reason for receiving massage therapy today? _____

_____

_____

GENERAL INFORMATION

Have you ever been in a motor vehicle accident?: ____yes ____no

If yes, how long ago? ____<6 months ____1 year ____>2 years

Recreational or sporting activities: _____

_____

Daily exercise: _____

Posture assumed throughout the day: _____

List stress reduction activities: _____

_____

See other side...

MUSCULO-SKELETAL

- ☐ bone or joint disease
- ☐ tendonitis
- ☐ bursitis
- ☐ fractures
- ☐ arthritis
- ☐ sprains/strains
- ☐ low back pain
- ☐ hip/leg pain
- ☐ neck/shoulder/arm pain
- ☐ headaches/head injuries
- ☐ migraines
- ☐ jaw pain/TMJ syndrome
- ☐ spasms/cramps
- ☐ other (please specify)

CIRCULATORY

- ☐ heart disease
- ☐ varicose veins
- ☐ blood clots
- ☐ high blood pressure
- ☐ low blood pressure
- ☐ lymphedema
- ☐ breathing difficulty
- ☐ sinus problems
- ☐ allergies
- ☐ CCHF
- ☐ myocardial infarction
- ☐ stroke
- ☐ phebitis
- ☐ pacemaker
- ☐ other (please specify)

INFECTIOUS DISEASES

- ☐ hepatitis
- ☐ TB
- ☐ HIV
- ☐ other (please specify)

SKIN

- ☐ allergies
- ☐ rashes
- ☐ athletes foot
- ☐ warts
- ☐ other (please specify)

DIGESTIVE

- ☐ constipation
- ☐ gas/bloating
- ☐ diverticulitis
- ☐ irritable bowel syndrome
- ☐ crohn's/colitis
- ☐ other (please specify)

NERVOUS SYSTEM

- ☐ herpes/shingles
- ☐ numbness/tingling
- ☐ chronic pain
- ☐ fatigue
- ☐ sleep disorder
- ☐ other (please specify)

REPRODUCTIVE

- ☐ pregnant (trimester)
- ☐ PMS
- ☐ other (please specify)

RESPIRATORY

- ☐ chronic cough
- ☐ shortness of breath
- ☐ emphysema
- ☐ bronchitis
- ☐ asthma
- ☐ other (please specify)

OTHER

- ☐ eating disorder
- ☐ depression
- ☐ drug/alcohol addiction
- ☐ nicotine/caffeine
- ☐ diabetes
- ☐ vision loss
- ☐ hearing loss
- ☐ CFS/fibromyalgia
- ☐ other (please specify)

See other side...

FOR YOUR INFORMATION:

An Accurate health history is important to ensure that it is safe for YOU to receive massage therapy treatment. If your health status changes in the future, please let us know. All information gathered for this treatment is confidential except as required or allowed by law or except to facilitate diagnosis, assessment or treatment. You will be asked to provide written authorization for the release of any information.

ACKNOWLEDGEMENT:

In keeping with the Health Canada Consent Act of 1996, it is my choice to receive massage therapy. I am aware that it is not necessary to remove all articles of clothing for treatment, and that I can decided to remove only the clothing which makes me feel comfortable. I will give consent to my massage therapist to treat only those body parts for which I give permission. I agree to communicate with my massage therapist at any time that I feel my well being is being compromised. I am aware that I may terminate treatment at any point during the massage, at my discretion, and without reason. I am aware that I may experience possible side effects from the massage treatment, such as; temporary discomfort within the muscles 24-48 hours post treatment, or temporary dizziness.

NAME: .....
(please print)

SIGNATURE: ..... DATE: .....

PARENTAL/GUARDIAN SIGNATURE: ..... DATE: .....