MASSAGE THERAPY PATIENT HISTORY

Patient's Name: _____ Alberta Health Care #: _____ Date: _____

Address: _____Home Phone #: _____Work Phone #: _____

Cell Phone#: _____ Email: _____ Birth Date: D/ ___ M/ ___ Y/ _____

Age: ___ Sex: ☐ M ☐ F Married _____ Single _____ Medical Doctor: _____Doctor Phone #: _____

In case of emergency, contact: _____Phone: _____

Whom may we thank for referring you to our office? _____

1. Please indicate conditions you are experiencing or have experienced.

Cardiovascular
- ❑ High blood pressure
- ❑ Low blood pressure
- ❑ Chronic congestive heart failure
- ❑ Heart attack
- ❑ Phlebitis/varicose veins
- ❑ Stoke/CVA
- ❑ Pacemaker or similar device
- ❑ Heart disease
- ❑ Dizziness/vertigo
- ❑ Seizures

Is there any family history of any of the above? ❑ Yes ❑ No

_____

Head and Neck
- ❑ History of headaches
- ❑ History of migraines
- ❑ Vision problems
- ❑ Vision loss
- ❑ Ear problems
- ❑ Hearing loss

Women
- ❑ Pregnant

Due date: _____
- ❑ Previous pregnancy complications:

_____
- ❑ Menopausal complications:

_____
- ❑ Menstrual complications:

_____
- ❑ Gynecological Conditions:

_____

Respiratory
- ❑ Asthma
- ❑ Bronchitis
- ❑ Emphysema
- ❑ Chronic cough
- ❑ Shortness of breath

Is there any family history of any of the above? ❑ Yes ❑ No

Skin Conditions
- ❑ Open sores
- ❑ Eczema
- ❑ Psoriasis
- ❑ Rash
- ❑ Warts

Muscle/Joint
- ❑ Neck
- ❑ Back (Lower)
- ❑ Back (Mid)
- ❑ Back (Upper)
- ❑ Shoulders
- ❑ Elbow
- ❑ Wrist/Hand
- ❑ Hip
- ❑ Knee
- ❑ Ankle/Foot
- ❑ Spine

Men
- ❑ Enlarged prostate
- ❑ Libido issues
- ❑ Other: _____

Digestive
- ❑ Constipation
- ❑ Chrone's Disease
- ❑ Colitis
- ❑ Irritable Bowel Syndrome
- ❑ Ulcers

Infectious Conditions
- ❑ Skin Conditions

_____
- ❑ Respiratory conditions

_____
- ❑ Hepatitis

Other
- ❑ Loss of sensation

Where: _____
- ❑ Diabetes

Onset: _____

Type: _____
- ❑ Allergies/Hypersensitivity

What? _____
- ❑ Epilepsy
- ❑ Cancer

Type: _____

Location: _____
- ❑ Arthritis

Is there a family history of arthritis?

❑ Yes ❑ No
- ❑ Hemophilia
- ❑ Fibromyalgia
- ❑ Chronic fatigue
- ❑ Scoliosis
- ❑ Polio/Post polio
- ❑ Osteoporosis

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

If yes, please describe:_____

3. Do you have any internal wires, artificial joints, pacemakers or special equipment? ❑ Yes ❑ No

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

5. Please mark the areas which are currently causing you symptoms of pain, stiffness, numbness or other forms of discomfort:

❑ Face	❑ Upper Back	❑ Arm(s)	❑ Hands(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				

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

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

8. Have you ever been involved in any other accidents? ❑ Yes ❑ No Date:_____

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

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

_____

11. Are you presently taking any prescribed medication(s)? ❑ Yes _____❑ No

12. Have you previously received massage therapy treatments? ❑ Yes ❑ At this clinic ❑ RMT ❑ Other_____❑ No

13. Please mark 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: _____

Parent/Guardian Signature: _____ Date: _____ Therapist Signature: _____