MASSAGE THERAPY

PATIENT HISTORY

Patient Information

Patient's Legal Name: ______________________________ Preferred Name__________________________ Date: ___________________

Address: ______________________________________ City:_______________________ Postal Code: ______________________

Home #: _______________________ Work #: _________________________ Cell #: ___________________________

Cell Provider (optional):_________________ Email (optional): __________________________________ *Your cell and email will not be shared with third parties & is used for appointment reminders. I understand that I can opt out at any time by informing CARE that I no longer wish to receive appointment reminders.*

Birth Date: D/ ___ M/ ____ Y/ ________ Age: ____ ☐ M ☐ F Married _____ Single ______

Occupation: _______________________________ Medical Doctor: ____________________________ Phone #: _________________

In case of emergency, contact: ____ Phone: _______________________

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

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
❑ Stroke/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
❑ Crohn'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

Relevant History

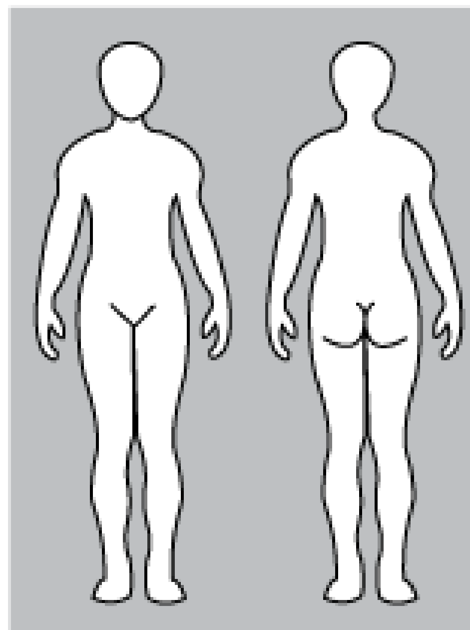
2. Do you have any medical conditions not listed above? ❑ Yes ❑ No
   If yes, please describe: ____
____
____

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:

Please indicate by marking areas on the chart using the following symbols:

oooo	Pins and Needles
////	Stabbing
xxxx	Burning
+++	Aching
= = =	Numbness
▲▲▲	Stiffness



Using the scale to the right, place a vertical line (|) relative to your current pain or discomfort

No pain

Worst possible pain

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 & when______________________________
____
____

11. Are you presently taking any prescribed medication(s)? ❑ Yes ❑ No
    If yes, please list: ____
____
____
____

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

14. What do you hope to gain from your massage therapy treatment? ____

I acknowledge that the Massage Therapist is not a physician & 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 & 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 & disclosed all 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 & complete to the best of my knowledge.

Consent to the Collection, Use and Disclosure of Personal Health Information: Maintaining the protection of your personal health information is required by provincial and federal law. This information will be securely maintained in charts or electronically for a minimum of ten years past the last date of treatment. To access this information, the Clinic must receive your written consent to release this information to a designated individual or organization. You also understand that this information will be accessible to and shared amongst each of the health service providers within the clinic for the purposes of providing integrated, patient centered health services for:

- Chiropractic/Massage Therapy/Acupuncture or other clinical services
- To obtain payment from a third-party insurance company for treatments provided, if applicable

I understand that I can withdraw my consent to collect, use and disclose my personal health information by providing written notice to the treating practitioner

Signature: _________________________________Date: ________________ Therapist Signature: _________________

Parent/Guardian Signature: ______________________ Date: ___________ Therapist Signature: _________________