

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