Confidential Patient Case History

***For your information*: An accurate health history is important to ensure that it is safe for you to receive a massage treatment. All information gathered for this treatment is confidential except as required by law or except to facilitate assessment or treatment. You will be asked to provide written authorization for release of any information.**

Name:_____ Date:_____ Occupation:_____

Address:_____ Fax/Email:_____

_____ Date of Birth:_____

Phone:(H)_____(B)_____ Who referred you?_____

Reason for visit (primary complaint)_____

Have you ever had massage therapy before? Y / N

Present involvement in other health care: Physiotherapy Chiropractic
Other: _____

Primary Care Physician:_____ Phone:_____

Current Medications:_____
Condition it treats:_____

Surgery:_____ Date:_____ Nature:_____

Injuries:_____ Date:_____ Nature:_____

Motor Vehicle Accident: Y / N Date:_____

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

I have read and understand the front and back of this form. The information given is correct and complete to my knowledge. I shall notify the therapist upon any changes or updates of my health or medications so my file information remains current. As stated in the Health Care Consent Act, I have the right to consent to all or part of the session, or to withdraw consent at any time. I have the right to know specifically what I am consenting to. If the description of the session beforehand is incomplete, I have the right to ask questions at any time and to have them adequately answered. I will communicate information such as pain/comfort levels throughout the session to ensure my own safety and the effectiveness of the session. I consent to treatment.

Signature: _____

****Please see reverse also ****

Health History: Please indicate conditions you are experiencing or have experienced:

Respiratory

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

Cardiovascular

- ❑ Varicose veins
- ❑ High blood pressure
- ❑ Low blood pressure
- ❑ CCHF
- ❑ Heart attack When:_____
- ❑ Phlebitis
- ❑ Stroke/CVA When:_____
- ❑ Pacemaker
- ❑ Heart condition

Skin

- ❑ Skin conditions
- ❑ Sensitive
- ❑ Rashes

Other Conditions

- ❑ Loss of sensation
- ❑ Diabetes: Type_____
- ❑ Allergies: Type_____
- ❑ Epilepsy
- ❑ Cancer: Type_____
- ❑ Arthritis: Type_____
- ❑ Eating disorder
- ❑ Depression
- ❑ Drug/alcohol addiction
- ❑ Smoker
- ❑ Chronic Fatigue Syndrome
- ❑ Fibromayalgia
- ❑ Osteoporosis
- ❑ Hemophelia
- ❑ Spinal condition: Type_____

Head / Neck

- ❑ Vision problems
- ❑ Vision loss
- ❑ Ear problems
- ❑ Hearing loss
- ❑ Headaches: tension / migraine

Infections

- ❑ Hepatitis
- ❑ Tuberculosis
- ❑ HIV

Soft tissue / joint discomfort and its nature

- ❑ Neck _____
- ❑ Low back _____
- ❑ Mid back _____
- ❑ Upper back _____
- ❑ Shoulders _____
- ❑ Arms _____
- ❑ Legs _____
- ❑ Knees _____
- ❑ Other _____
- ❑ Bursitis _____
- ❑ Tendinitis _____
- ❑ Sprain/strain _____
- ❑ TMJ _____
- ❑ Whiplash _____
- ❑ Frozen shoulder _____
- ❑ Degenerative disc _____
- ❑ Fractures _____

Digestive

- ❑ Constipation
- ❑ Gas/bloating
- ❑ Diverticulitis
- ❑ Irritable bowl syndrome

Nervous System

- ❑ Herpes
- ❑ Shingles
- ❑ Numbness/tingling
- ❑ Fatigue
- ❑ Sleep disorder
- ❑ MS

Women

- ❑ Pregnant: Due_____
- ❑ PMS
- ❑ Menopause

Please list any other conditions not mentioned above:_____