

Chart # _____

Date: _____

CONFIDENTIAL PATIENT CASE HISTORY FORM

Last Name _____ First Name _____ Male Female

Address _____ City _____

Province _____ Postal Code _____ Home Phone _____ Work Phone _____

Birth Date: (DD/MM/YYYY) _____ Occupation _____

May we contact you via e-mail? All contact information is kept confidential and we only send about 1 e-mail/month.

Yes, e-mail address _____ No, thanks.

Extended health insurance company _____ Policy # _____ Claim # _____

Medical doctor _____ Doctor's phone # _____

How did you hear about us? _____

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

Respiratory

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

Head and Neck

- History of headaches
- History of migraines
- Vision problems
- Vision loss
- Ear problems
- Hearing loss

Muscle/Joint

- Neck
- Back (lower)
- Back (mid)
- Back (upper)
- Shoulders
- Elbow
- Wrist/hand
- Hip
- Knee
- Ankle/foot
- Spine

Other

- Loss of sensation
Where? _____
- Diabetes
Onset: _____
Type: _____
- Epilepsy
- Cancer
Type/Location: _____
- Arthritis
- Hemophilia
- Fibromyalgia
- Chronic Fatigue
- Scoliosis
- Polio/post-Polio
- Osteoporosis

Women

- Pregnancy
Due Date: _____
- Previous pregnancy complications

Infectious Conditions

- Skin conditions
Describe: _____
- Respiratory Conditions
Describe: _____
- Hepatitis
- HIV

Skin Conditions

- Eczema
- Psoriasis
- Rash
- Warts
- Open sores

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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

For what condition are you seeking treatment today? _____

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

If yes, what types of treatment have you received (e.g. chiropractic, physiotherapy, acupuncture, etc)?

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)?

If yes, please list the medication(s) and the conditions for which it is being used if known:

Have you previously received massage therapy treatments? Yes No

If yes, where were you treated and by whom? _____

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

Note: 24 Hour Notice for Cancellation of Massage Appointments

I understand I will incur and be responsible for a fee of \$30.00 for same-day cancellations or missed appointments.

Initial here: _____