**Confidential Patient Case History Form**

Name: _____Email: _____
Address: _____ City: _____ Prov:_____
Postal Code _____ Phone # : _____ Birth Date: _____(m) _____(d) _____(y)
Occupation: _____
How did you hear about us? _____

**Please indicate conditions you are experiencing or have experienced:**

**Cardiovascular**
o High Blood Pressure
o Low Blood Pressure
o Heart Attack
o Phlebitis/Varicose Veins
o Stroke/CVA
o Pacemaker or similar device
o Heart Disease
o Dizziness/vertigo
o Seizures

**Respiratory**
o Asthma
o Bronchitis
o Emphysema
o Chronic Cough
o Shortness of breath

**Digestive**
o Constipation
o Chrones
o Colitis
o IBS
o Ulcers

**Head and Neck**
o History of headaches
o History of migraines
o Vision Problems
o Vision loss
o Ear Problems
o Hearing loss

**Muscle/Joint**
o Neck
o Back (lower)
o Back (middle)
o Back (upper)
o Shoulders
o Elbow
o Wrist/Hand
o Hip
o Knee
o Ankle/Foot
o Spine

**Other**
o Loss of sensation Where?_____.
o Diabetes
o Allergies/hypersensitivity
o What?_____.
o Epilepsy
o Cancer Type/Location:
o Arthritis
o Hemophilia
o Fibromyalgia
o Chronic fatigue
o Scoliosis
o Polio/Post Polio
o Osteoporosis

**Women**
o Pregnancy
Due Date:_____.
o Previous pregnancy complications
o Menopausal problems
o Gynecological conditions

**Infectious Conditions**
o Skin Conditions
o Respiratory Conditions
o Hepatitis

**Skin Conditions**
o Eczema
o Psoriasis
o Rash
o Warts
o Open Sores

**Do you have any medical conditions not listed above? Yes / No**
*If yes, please describe:*
_____

**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 | Arms | Hand(s) | Thigh(s) | Ankles(s) | Neck |
| Midback | Lowerback | Finger(s) | Knee(s) | Foot/Feet | Shoulder(s) | Elbow(s) |
| Wrist(s) | Hips(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.**

| _____ | _____ | _____ |
|---|---|---|
| *Print name* | *Signature* | *Date* |
| _____ | _____ | _____ |
| *Therapist name* | *Therapist Signature* | *Date* |