Confidential Case History

An accurate health history is important to ensure that it is safe for you to receive a massage therapy treatment. The CMTO requires that this history be updated on a yearly basis. If your health status changes in the future, please inform your therapist. All information is confidential except as required or allowed by law or to facilitate assessment of treatment.

NAME: ____ ADDRESS: ____

CITY:____ POSTAL CODE:____

PHONE NUMBER:___________________________________ DATE OF BIRTH:____

OCCUPATION:_____________________________________ FAMILY PHYSICIAN: _____________________________________

FAM. PHYSICIAN ADDRESS:____ TEL:_____________________________________

ALLERGIES:_______________________________________ CURRENT MEDICATIONS:__________________________________

Are you currently being treated by another health care professional? □Yes □No ____

Have you received massage therapy before? □Yes □No

SOURCE OF REFERRAL:____

CHIEF COMPLAINTS:____

TYPE OF PAIN:______________________________DOES IT RADIATE:____________WHERE?____________________________________

WHAT RELIEVES PAIN/CONDITION?____

WHAT AGGRAVATES PAIN/CONDITION?____

OTHER THERAPIES?____

DESCRIBE & DATE PAST INJURIES/SURGERIES:____

MOTOR VEHICLE ACCIDENT: □YES □NO DATE(S):____

EMERGENCY CONTACT:_____________________________ TELEPHONE:____

HEALTH HISTORY - PLEASE CHECK THE CONDITIONS THAT APPLY:

HEAD/NECK
- □ headaches/migraine
- □ vision problems
- □ hearing problems
- □ ear/jaw/tooth pain
- □ head trauma/concussion
- □ allergies
- □ neck pain/stiffness/injury

SKIN
- □ sensitive skin
- □ rashes/eruption
- □ cold sores
- □ contagious conditions
- □ bruise easily

DIGESTION
- □ loss of appetite
- □ constipation/diarrhea
- □ nausea
- □ gas
- □ liver/gallbladder
- □ ulcer
- □ alcohol consumption
- □ celiac/Chrohn's/Colitis

RESPIRATORY
- □ chronic cough
- □ congestion
- □ asthma or bronchitis
- □ emphysema
- □ shortness of breath
- □ family history of any of above

Details:____________________

CARDIOVASCULAR
- □ high blood pressure
- □ low blood pressure
- □ poor circulation
- □ congestive heart failure
- □ varicose veins/phlebitis
- □ dizziness
- □ chest pain/angina
- □ heart disease
- □ heart attack/stroke
- □ family history of any of above

Details:_____________________

OTHER
- □ cancer
- □ epilepsy/seizures
- □ hepatitis
- □ HIV
- □ hemophilia
- □ lupus
- □ diabetes
- □ mental illness______________

MUSCLES/JOINTS/NERVES
- □ swelling
- □ limitation of movement
- □ fibromyalgia
- □ chronic fatigue syndrome
- □ pain/stiffness/injury
  - □neck □arm/shoulder L/R
  - □mid back □hip/thigh L/R
  - □low back □knee/leg L/R
- □ multiple sclerosis
- □ degenerative disc disease
- □ spasm/strain/sprain
- □ tendonitis/bursitis
- □ fractures/pins/wires/plates
  - □artificial joints
- □ sports/work-related injury
- □ repetitive strain injury
- □ carpal tunnel syndrome- L/R wrist
- □ osteoarthritis/rheumatoid arthritis
- □ osteoporosis
- □ Other________________________

ARE YOU PREGNANT? □Yes □No **DUE DATE:____________________ GYNAECOLOGICAL CONDITIONS:__________________________**

For any missed or cancelled appointment with less than 24 hour notice there will be a $40.00 fee payable at your next visit. Due to the patient volume in this clinic, if given 24 hour notice it will allow me time to contact patients on the waiting list to fill your appointment time.

Release of Personal Information

I hereby fully authorize the Registered Massage Therapist to exchange medical and/or other information necessary with other medical professionals handling my case, WSIB (if applicable), and/or my motor vehicle auto insurance company (if applicable) and any third party payers and benefit plan Insurance companies.

I understand that this information will be used to provide me with the most individualized and optimal massage therapy treatment care and will be confidential.

Consent for Treatment

I hereby offer my consent to participating in massage therapy treatment, which I have been told may include pain control modalities, exercise prescription, manual therapy, passive muscle stretching, and health care education/teachings. I also give my consent to have communications sent to me by email and text messages by my Massage Therapist.

I understand that I may withdraw my consent at any time without penalty.

□ I HAVE READ AND ACKNOWLEDGED THE PRIVACY POLICY OF THIS MASSAGE THERAPY PRACTICE.

____ ____

Signed Consent (Signature) **Date**

Therapist's additional notes:

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