CONFIDENTIAL CASE HISTORY - MASSAGE THERAPY

Date: _____ **Email address:** _____ **Birthdate**: _____

Last Name: _____ **First Name:** _____

Address: _____ **City:** _____ **Postal Code:** _____

Home Phone: _____ **Work Phone:** _____ **Cell Phone:** _____

Health Insurance Company: _____ **Member ID:** _____ **Policy/Group:** _____

How did you hear about me? _____
Is this your first massage? ____ If no, previous R.M.T.'s name: _____
Medical Doctor's name: _____ Phone number: _____
Current medications and what they treat: _____
_____
Have you ever been in a car accident? ____ If yes, please list the date, treatment received and outcome:
_____
_____
Other major past illnesses, surgeries and injuries, when they occurred, treatment received and outcome:
_____
_____
Special notes or other: (internal pins/wires, artificial joints/limbs, special equipment) _____
_____
What is your occupation? _____ What are your main tasks at work?
_____
Do you have any allergies? _____
Current sleeping patterns (length, position, quality):_____
Exercise/activities (length, amount/week):_____
Eating habits (dominant food groups, meals/day):_____
Alcohol/tobacco intake (daily/weekly):_____
Other professionals (Chiro, Physio, etc.) you are receiving treatment from and their phone numbers: _____
_____
Are you or think you might be pregnant? _____ Due date: _____

CURRENT HEALTH CONDITION

What brings you in to see us? _____
When did it start? _____ Have you experienced this before? _____
What treatment(s) did you receive for this previously and what was the outcome?_____
_____
The pain is: ___ constant ___comes & goes ___getting worse ___relative to certain activities/movements.
Does the pain travel away from the site of your main complaint? _____ Where to? _____
_____
The complaint is interfering with: _____work _____sleep _____ activities of daily living _____sports
Have you consulted others health professionals regarding this condition? (chiro, physio, etc.)_____
What was their diagnosis?_____
On a pain scale of 1-10, 1 being the least and 10 being the greatest, what do rate your pain level? _____
How would you describe your pain or what you're feeling? _____
What makes your condition: Worse?_____
Better? _____

Have you been diagnosed with or have you ever experienced any of the following?

If **Yes**, please mark with an "**X**" on the line provided.

Circulatory
___ Chronic congestive heart failure
___ Heart disease
___ Other heart condition
___ High blood pressure
___ Low blood pressure
___ Varicose veins
___ Phlebitis
___ Deep vein thrombosis
___ Raynaud's disease/phenomenon
___ Buerger's disease

Respiratory
___ Chronic cough
___ Bronchitis
___ Asthma
___ Emphysema
___ Shortness of breath

Skin
___ Sensitivities to oils, lotions, detergents
___ Other allergies or hypersensitivities
___ Irritated skin conditions
___ Contagious conditions
___ Frostbite
___ Lack of sensation

Digestive
___ Constipation
___ Diarrhea
___ Liver/gall bladder problems
___ Ulcers
___ Indigestion

Nervous system
___ Epilepsy
___ Multiple sclerosis
___ Cerebral palsy
___ Parkinson's
___ Nerve lesion
___ Sciatica
___ Carpal tunnel syndrome

Have you ever suffered from:
Heart Attack?_____ Date:_____
Stroke?_____ Date:_____

General
___ Cancer/tumors
___ Undiagnosed lump
___ Diabetes
___ Kidney/bladder problems
___ Hernia
___ Drug/alcohol addiction or withdrawal
___ Infectious conditions (hepatitis, HIV, etc.)
___ Eating disorder
___ Loss of vision or hearing
___ Headaches
___ Sinus problems
___ Fibromyalgia
___ Chronic fatigue syndrome
___ Dizziness

Women
___ Recent abortion or vaginal birth
___ Menstrual difficulties
___ Menopause

Musculoskeletal
___ Scoliosis
___ Bone or joint disease
___ Arthritis
___ Joint instability
___ Tendinitis
___ Fractured bones
___ Jaw pain (TMJ)
___ Whiplash

Please list and provide details of any other condition that you are experiencing that is not listed above or provide further details on above conditions that apply to you:_____
_____
_____

I hereby declare that I have stated all medical conditions that I am aware of and that the above information is correct and current. I recognize that it is my responsibility to notify the therapist of any changes in my health status. I am aware that this case history is required to assist my therapist in completing an assessment and forming a treatment plan. I understand that the above information is to remain confidential.

Client Signature:_____ Date:_____

CONSENT TO TREATMENT

I,_____, hereby declare that all information is correct, and if it should change, it is my responsibility to notify the therapist of these changes at the next scheduled appointment.

I have given consent to my Massage Therapist to speak to any of my other medical practitioners (if necessary), to clarify any information divulged on the Case History Form, during assessment, or during treatment.

A treatment plan has been explained to me by the therapist. I have also been informed of the expected benefits to the treatment, potential effects from the treatment, and possible consequences of not receiving this treatment.

I have been informed that I may stop or alter my treatment at any time.

I understand and agree with the fees for massage therapy and the consequences of improperly cancelled appointments.

The therapist has answered any questions I may have had to my satisfaction. Therefore, I give my consent to begin the proposed treatment.

CANCELLATION POLICY

I, _____, understand that my appointments are reserved especially for me and that I must call my therapist as soon as I know that I cannot keep an appointment.

I understand that my appointment will be confirmed no less than 36 hours preceding my appointment.

I am aware that I will be billed 50% of the treatment cost for each missed appointment or cancellation made less than 24 hours preceding my appointment, at the discretion of the therapist. I am aware that the cancellation fee will be charged to my account and that I am responsible for paying the fee on my next visit. I am aware that an invoice will be mailed to me, if I have no upcoming appointments, and that it is payable upon receipt.

Signature of Client:_____

Date:_____

Signature of Parent/Guardian (if applicable):_____

Date:_____

Signature of Massage Therapist:_____