MEDICAL HISTORY FORM

The reasons for obtaining this information are:
- This is a College of Massage Therapists requirement
- to enable the therapist to individualize treatment
- to help identify other possible conditions
- to alert the therapist to conditions for which certain massage therapy modalities are contraindicated

Name: ______________________ Date: ______________
Address: ______________________ Birth Date: ______________
City: ____________ Postal Code: ____________ Type of Work: ______________
Phone: ____________ Cell: ____________ Weekly Work Hours: ______________
Email: ______________________
Primary Health Care Professional: Name ______________ Phone ______________
Address ______________ May we contact him/her? YES NO Last Appt ______________
Who referred you to this clinic/How did you hear about us?: ______________
Your reasons for attending this Clinic: ______________ Work-related injury?: YES NO
Describe your general health status: ______________

MUSCLES / JOINTS:
___ tension headache / migraine
___ history of tension headaches
___ history of migraines
___ whiplash
___ head trauma / concussion
___ loss of coordination
___ neck stiffness / pain / injury
___ tooth / jaw / ear pain
___ shoulder stiffness / pain
___ arm pain / weakness / tingling
___ back pain / injury
___ sciatica / hip pain / buttock pain
___ scoliosis
___ knee pain
___ leg pain / weakness / tingling
___ foot or ankle pain
___ strain / sprain
___ tendonitis / bursitis
___ fractures: ____________
___ pins / wires / special equipment
___ family history of osteoarthritis

NERVES:
___ vision loss
___ hearling loss
___ loss of sensation
___ nervousness / anxiety
___ loss of sleep
___ nerve pain

SKIN:
___open sores / cuts / warts
___ rashes / athlete's foot
___ sensitive skin / hives
___ heat / cold sensitivities

LIFESTYLE QUESTIONS:
___ exercise regularly
___ poor energy levels
___ poor sleeping patterns
___ smoke

HEART / CIRCULATION:
___ heart disease
___ history of heart attack
___ history of stroke
___ chronic congestive heart failure
___ family history of cardiovascular difficulties
___ high blood pressure
___ low blood pressure
___ phlebitis / varicose veins
___ hardening of the arteries
___ chest pain / angina
___ rapid heartbeats
___ cold hands & feet
___ swelling
___ light headed / fatigue
___ poor healing
___ anemia
___ bruise easilt / hemophilia
___ presence of pacemaker or similar device

LUNGS / RESPIRATION:
___ asthma
___ bronchitis
___ emphysema
___ family history of respiratory difficulties
___ allergies
  ___ environmental
  ___ nuts
  ___ other: ____________
___ hypersensitivity reaction
___ anaphylactic response
___ chronic cough
___ nasal obstruction
___ shortness of breath

WOMEN:
___ pregnant
due date: ____________
___ gynaecological conditions

DIGESTION:
___ unusual loss / gain weight
___ diarrhea / constipation
___ abdominal pain

INFECTION CONDITIONS:
___ skin conditions
___ respiratory conditions
___ hepatitis
___ HIV
___ herpes
___ tuberculosis
___ other: ____________

OTHER DIAGNOSED DISEASES OR MEDICAL CONDITIONS:
___ digestive (colitis, IBS ulcers)
___ diabetes
___ jaundice / hepatitis
___ liver or gall bladder problems
___ hernia
___ urinary: ____________
___ mental illness
___ depression
___ degenerating discs
___ osteoarthritis
___ rheumatoid arthritis
___ osteoporosis
___ scoliosis
___ muscle disease
___ bone disease
___ fibromyalgia / chronic fatigue
___ multiple sclerosis
___ epilepsy
___ rneurological disorders

CANCER:
___ recent disgnosis
___ undergoing treatment
___ remission
___type: ____________

NAME DATE

Have you recieved Massage Therapy before? ______ Yes ______ No If yes, how often? ______________________
For what reason(s)? ______________________

Are you currently involved in treatment with other Health Care Professionals? (Chiropractor, Physiotherapist, Naturopath, Osteopath, Specialist, etc) ______ Yes ______ No If yes, who?: ______________________
For what reason(s)? ______________________

MEDICATIONS / CONDITIONS

Please list all current and/or regular medications, including aspirin of other over-the-counter pharmaceuticals/supplements:

MEDICATION	CONDITION USED FOR

INJURY / ACCIDENT HISTORY

Please list major injuries or prior car accidents, including approcimate date, areas affected and treatment recieved (Physiotherapy, Chiropractic, Massage Therapy

DATE	TYPE OF INJURY / AREA AFFECTED	TREATMENT RECEIVED

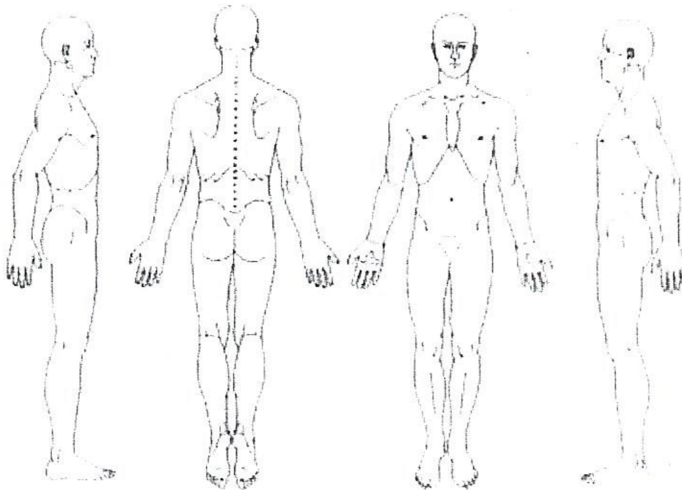
SURGERY

Please list all past surgeries, including approximate date

DATE	SURGERY

Indicate on the diagram areas of pain, joint and muscle stiffness, tingling and/or numbness.

PRIMARY COMPLAINT: ______________________



CONSENT

I understand that Massage Therapy involved manipulating the soft tissures and joints of the upper body in order to rehabilitate, improve function, and enhance well-being. The position of the body and the draping used are designed to provide comfort and warmth. The likely risks and benefits of my treatment have been explained to me and I understand that I am free to make inquiries or request modifications in any aspect of my session at any time (position, depth of pressure, draping). The therapists at The Healing Centre work collectively; therefore, my health information may be communicated within the clinic as needed. I am free to specify confidentiality to one therapist of I so desire.

I understand the information given on this form is absolutely confidential, and will only be released to other Health Care Professionals or Legal Representatives with my written consent or as dictated by the Massage Therapy Act, Health Care Consent Act, the Regulated Health Professions Act and the Personal Health Information Protection Act.
I understand a notice of 24 hours is required for cancellation or to reschedule my appointment, or a fee equivalent to my scheduled treatment will be charged.

DATE: ______________________ SIGNATURE: ______________________