

Confidential Medical History Form

Name _____ Male Female

Address _____ City _____ Prov _____

Postal Code _____ Home Phone: _____ Work Phone _____

Birth Date: _____ (m) _____ (d) _____ (y) Occupation: _____

Medical Doctor: _____ Doctor Phone #: _____

Emergency Contact: _____ Contact Phone #: _____

How did you hear about us? _____ Email Address: _____

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
- Dizziness / vertigo
- Seizures
- Other _____

Is there a family history of any of the above?
 Yes No

Muscle/Joint

- Neck
- Back (lower)
- Back (mid)
- Back (upper)
- Shoulders
- Elbows
- Wrist /Hand
- Hip
- Knee
- Ankle / Foot
- Spine
- Other _____

Respiratory

- Asthma
 - Bronchitis
 - Emphysema
 - Shortness of breath
 - Chronic Cough
 - Other _____
- Is there a family history of any of the above?*
 Yes No

Nervous System Disorders

- Numbness _____
- Tingling _____
- Neurological Pain
- Parkinson`s
- Cerebral Palsy
- Multiple Sclerosis
- Alzheimers`s
- Klumpke`s
- Erb`s
- Foot Drop
- Carpal Tunnel Syndrome
- Thoracic Outlet Syndrome
- Other _____

Head and Neck

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

Digestive

- Constipation
- Chrones Disease
- Colitis
- Irritable Bowel Syndrome
- Ulcers
- Other _____

Women

- Pregnancy
 Due Date: _____
- Previous pregnancy complications

- Menopausal problems

- Gynecological conditions

- Endometriosis
- Other _____

Infectious Diseases

- Skin Conditions
 Describe: _____
- Respiratory Conditions
 Describe: _____
- Hepatitis
- Other _____

Other

- Loss of sensation
 Where ? _____
- Diabetes
 Onset: _____
 Type: _____
- Allergies/hypersensitivity
 What? _____
- Epilepsy
- Cancer
 Type/Location: _____
- Arthritis
 Is there a family history of arthritis?
 Yes No
- Haemophilia
- Fibromyalgia
- Chronic fatigue
- Scoliosis
- Polio / Post Polio
- Osteoporosis
- Thyroid Disorders
- Other _____

Men

- Enlarged Prostate
- Libido Issues
- Other _____

Skin Conditions

- Eczema
- Psoriasis
- Warts
- Rash
- Open sores
- Other _____

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(s)	Hand(s)	Thigh(s)	Ankle(s)	Neck
Mid back	Elbow(s)	Finger(s)	Knee(s)	Shoulder(s)	Feet	Lower back
Wrist(s)	Hip(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 ever 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 medication(s) (prescribed and non-prescribed)? 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. I authorize and grant permission to the Registered Massage Therapist to perform massage therapy treatments.

Signature

Date

Therapist Signature