Confidential
Massage Therapy Patient Case History Form

Patient Information

First Name: _____ Last Name: _____

Address: _____ Apartment: ____

Town/City: _____ Province: _____ Postal Code: _____

Home Tel: (____) _____ Work Tel.: (____) _____ Cell: (____) _____

E-Mail: _____ Birth Date: _____ Age: _____ Sex: ___

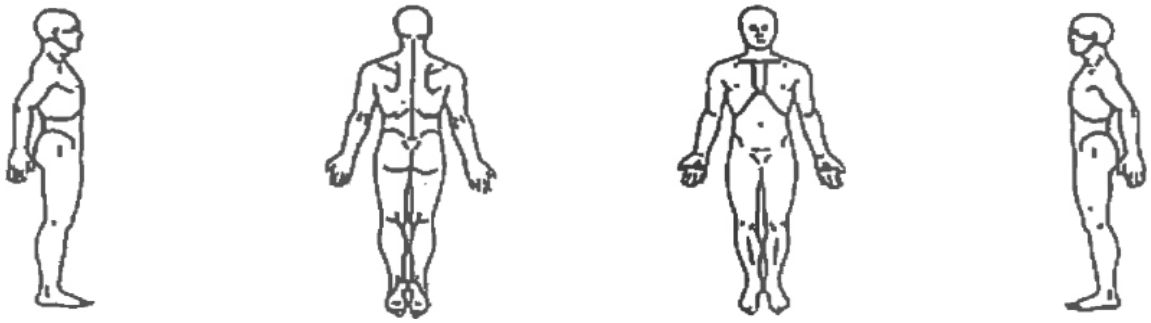
Medical History

Present Complaint(s) _____

_____

Are you in pain now? ❑ Yes ❑ No

Please indicate the location of your pain on the diagrams below: X for pain; O for stiffness; N for numbness



Have you had any treatment for the above complaint?

❑ Massage Therapist ❑ Chiropractor ❑ Physiotherapist ❑ Medical Doctor ❑ Other

Do you have to take any medications prior to your arrival to the clinic? ❑ Yes ❑ No

If yes, please list _____

Are you on any medication right now? ❑ Yes ❑ No

If yes, which one(s)? _____

Are you allergic to oils or creams? ❑ Yes ❑ No

If yes, which one(s)? _____

Do you stretch regularly? ❑ Yes ❑ No

Do you exercise regularly? ❑ Yes ❑ No

Previous Injuries / Serious Illnesses

1. Type: _____ Date: _____

   Explain: _____

2. Type: _____ Date: _____

   Explain: _____

3. Type: _____ Date: _____

   Explain: _____

Please indicate if you have any of the following conditions:

Head / Neck		
current	previous	
❑	❑	tension headache
❑	❑	sinus headache
❑	❑	migraine
❑	❑	vision problems
❑	❑	contact lenses
❑	❑	earaches
❑	❑	hearing problems
❑	❑	herniated disk

Cardiovascular		
current	previous	
❑	❑	high blood pressure
❑	❑	low blood pressure
❑	❑	poor circulation
❑	❑	heart disease
❑	❑	stroke
❑	❑	varicose veins
❑	❑	phlebitis
❑	❑	pacemaker

Respiratory		
current	previous	
❑	❑	asthma
❑	❑	chronic cough
❑	❑	shortness of breath
❑	❑	bronchitis
❑	❑	emphysema

Digestive I Urinary		
current	previous	
❑	❑	digestive problems
❑	❑	constipation
❑	❑	liver / gall bladder
❑	❑	kidney / bladder
❑	❑	colitis / crone's
❑	❑	diabetes
❑	❑	ulcers

Muscle I Joint pain		
current	previous	
❑	❑	neck
❑	❑	lower back
❑	❑	mid back
❑	❑	upper back
❑	❑	shoulders
❑	❑	hip: left / right
❑	❑	leg: left / right
❑	❑	knee: left / right
❑	❑	ankles: left / right
special note		
pins		
wires		
artificial joints I limbs		

Infectious Conditions			
current	previous		type
❑	❑	tuberculosis	
❑	❑	aids / HIV	
❑	❑	hepatitis	
❑	❑	Infectious skin condition(s)	
Skin			
current	previous		type / location
❑	❑	skin condition(s)	
❑	❑	bruise easily	
❑	❑	plantar warts	
❑	❑	loss of sensation	
❑	❑	eczema / psoriasis	

Other Conditions:

❑ Epilepsy ❑ Fibromyalgia ❑ Cancer ❑ Arthritis ❑ Hemophilia ❑ Osteoporosis ❑ Scoliosis

❑ Chronic Fatigue ❑ Polio / Post-Polio Are you pregnant? ❑ Yes ❑ No

Doctor's Name: _____ Phone Number _____

Clinic Name / Address: _____

Lifestyle

Alcohol consumption (drinks / week)_____ Insomnia: ❑ Yes ❑ No Average hours of sleep/night _____

Water consumption (glasses/day) _____ Smoker ❑ Yes ❑ No How many / day _____

Eating habits (do you eat regular meals?) ❑ Yes ❑ No Are you feeling stressed/depressed? ❑ Yes ❑ No

How do you deal with your stress/emotions?_____

Treatment Goals

(Please describe what would you like to get out of the treatment?)

_____

_____

_____

Date: _____ Signature of Patient / Guardian _____