

**MASSAGE THERAPY CASE HISTORY OUTLINE**

The information provided on this form is confidential and used for no other purpose

Name: \_\_\_\_\_ Birthdate: \_\_\_\_\_  
 (For returning clients) Has your address changed?  Yes  No Gender:  Female  Male  
 Address: \_\_\_\_\_ City, Province: \_\_\_\_\_  
 Postal code: \_\_\_\_\_ Home Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_  
 Occupation: \_\_\_\_\_ Work Phone: \_\_\_\_\_

**Email:** \_\_\_\_\_

If you would like to receive any of the following, please indicate with a check mark

I consent to have Alton Physiotherapy communicate with me via text message to the cell number specified above. Initials: \_\_\_\_\_

I consent to have Alton Physiotherapy send my appointment reminders to the email address specified above

I would like to receive the electronic newsletter or other electronic communications from Alton Physiotherapy

Were you referred to Alton?  No  Yes Please tell us how you found us: \_\_\_\_\_

Family Doctor: \_\_\_\_\_ City of Practice: \_\_\_\_\_

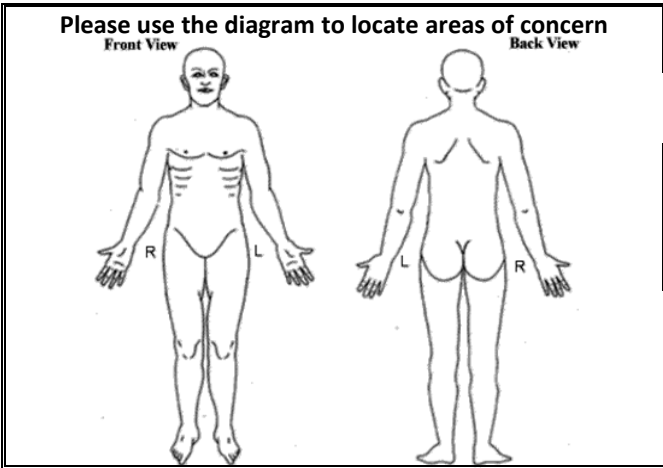
**CURRENT HEALTH STATUS**

Reason(s) for consulting our office today: \_\_\_\_\_

When did this begin? \_\_\_\_\_ Has it occurred before?  Yes  No

How would you describe it?  Achy  Dull  Numb  Sharp

Stabbing  Throbbing  Tingling  Other: \_\_\_\_\_



Please indicate if it is changing:  
 worse  better  Unchanged

What aggravates it (makes it worse)?  
 \_\_\_\_\_

What relieves it (makes it better)?  
 \_\_\_\_\_

Can you relate it to any of the following?  
 hobby  Car accident  Sports injury  
 Work accident  
 Other: \_\_\_\_\_

What have you tried to resolve this?  
 \_\_\_\_\_

**MASSAGE / TREATMENT INFORMATION**

Have you received a professional massage before?  Yes  No If yes, how often?  
 What results are you looking for with massage? \_\_\_\_\_

**WAIVER OF CONSENT**

I Certify that the information given on this form is true, and accurately reflects my past and present health status and that I will notify my massage therapist of any future changes in my health history. I consent to be treated for the aforementioned primary complaint, as well as any additional complaint(s) I discuss fully with my massage therapist in the future.

I understand that I may change my mind regarding any aspect of the treatment at any time and I may withdraw my consent with the intent of altering or discontinuing treatment.

Please note that **1 business day cancellation notice is required**. I understand that if I fail to give sufficient notice of cancellation, a **\$10 late cancellation fee** will be charged. Subsequent late cancellations will result in a **full treatment fee being charged**.

Client Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Registered Massage Therapist Signature: \_\_\_\_\_

**HEALTH HISTORY**

Please indicate (with a checkmark) which of the following you have had, where in the body and when(date):

- Car accident (date): \_\_\_\_\_
- Work/Sports-related injury: \_\_\_\_\_ - Body part: \_\_\_\_\_ R / L
- Fractures: \_\_\_\_\_ Dislocations: \_\_\_\_\_
- Surgeries: \_\_\_\_\_
- Have you had an X-ray or imaging for any of the above? \_\_\_\_\_
- Metal fixations, screws, pins, plates, wires, artificial joints, limbs, or special equipment? \_\_\_\_\_
- Medications: \_\_\_\_\_

Please indicate with a check mark the conditions that apply to you:

- |  |   |   |   |
|--|---|---|---|
| <p><b>Musculoskeletal</b></p> <ul style="list-style-type: none"> <li><input type="checkbox"/> headaches</li> <li><input type="checkbox"/> Jaw pain / TMJ</li> <li><input type="checkbox"/> Neck / shoulder</li> <li><input type="checkbox"/> Arm pain – Right/left</li> <li><input type="checkbox"/> Upper / mid back</li> <li><input type="checkbox"/> Low back / hip</li> <li><input type="checkbox"/> Leg pain – Right/left</li> <li><input type="checkbox"/> Knee pain – Right/left</li> <li><input type="checkbox"/> Tendonitis / bursitis</li> <li><input type="checkbox"/> Sprains / strains</li> <li><input type="checkbox"/> Osteoporosis</li> <li><input type="checkbox"/> Arthritis</li> <li><input type="checkbox"/> "flat feet"</li> <li><input type="checkbox"/> Other: _____</li> </ul> <p><b>Miscellaneous</b></p> <ul style="list-style-type: none"> <li><input type="checkbox"/> Anxiety</li> <li><input type="checkbox"/> Depression</li> <li><input type="checkbox"/> Unexplained Weight loss</li> <li><input type="checkbox"/> Restless Leg syndrome</li> </ul> | <p><b>Cardiovascular</b></p> <ul style="list-style-type: none"> <li><input type="checkbox"/> High blood pressure</li> <li><input type="checkbox"/> Low blood pressure</li> <li><input type="checkbox"/> Heart disease</li> <li><input type="checkbox"/> Heart attack</li> <li><input type="checkbox"/> Pace maker/device</li> <li><input type="checkbox"/> Stroke / CVA</li> <li><input type="checkbox"/> Varicose veins</li> <li><input type="checkbox"/> Difficulty breathing</li> <li><input type="checkbox"/> Chronic cough</li> <li><input type="checkbox"/> Sinus problems</li> <li><input type="checkbox"/> Allergies</li> <li><input type="checkbox"/> Other: _____</li> </ul> <p><b>Infection</b></p> <ul style="list-style-type: none"> <li><input type="checkbox"/> Herpes</li> <li><input type="checkbox"/> Hepatitis</li> <li><input type="checkbox"/> Plantar warts</li> <li><input type="checkbox"/> TB</li> <li><input type="checkbox"/> HIV / AIDS</li> <li><input type="checkbox"/> Other: _____</li> </ul> | <p><b>Nervous System</b></p> <ul style="list-style-type: none"> <li><input type="checkbox"/> Chronic pain</li> <li><input type="checkbox"/> Numbness / tingling</li> <li><input type="checkbox"/> Fatigue</li> <li><input type="checkbox"/> Insomnia</li> <li><input type="checkbox"/> Loss of sensation</li> <li><input type="checkbox"/> Other: _____</li> </ul> <p><b>Skin</b></p> <ul style="list-style-type: none"> <li><input type="checkbox"/> Allergies</li> <li><input type="checkbox"/> Infections</li> <li><input type="checkbox"/> Rashes</li> <li><input type="checkbox"/> Wounds / scars</li> <li><input type="checkbox"/> Bruise easily</li> <li><input type="checkbox"/> Other: _____</li> </ul> <p><b>Women</b></p> <ul style="list-style-type: none"> <li><input type="checkbox"/> Menstrual problems</li> <li><input type="checkbox"/> Gynaecological surgeries: _____</li> <li><input type="checkbox"/> Pregnant Due Date: _____</li> <li><input type="checkbox"/> Pregnant Due Date: _____</li> <li><input type="checkbox"/> Other: _____</li> </ul> | <p><b>Pathologies</b></p> <ul style="list-style-type: none"> <li><input type="checkbox"/> Liver</li> <li><input type="checkbox"/> Kidney – Right/Left</li> <li><input type="checkbox"/> Bladder</li> <li><input type="checkbox"/> Diabetes</li> <li><input type="checkbox"/> Cancer</li> <li><input type="checkbox"/> Epilepsy</li> <li><input type="checkbox"/> Vision loss</li> <li><input type="checkbox"/> Hearing loss</li> <li><input type="checkbox"/> Dizziness/vertigo</li> <li><input type="checkbox"/> Thyroid problem</li> </ul> <p><b>Digestive System</b></p> <ul style="list-style-type: none"> <li><input type="checkbox"/> Constipation</li> <li><input type="checkbox"/> Irritable bowel syndr.</li> <li><input type="checkbox"/> Other: _____</li> </ul> |
|--|---|---|---|
- Do you wear orthotics?     Yes     No
- Do you wear compression / support socks or garments?     Y     N
- Do you smoke?     Y     N

I hereby confirm that the above information is correct, to the best of my knowledge.

\_\_\_\_\_

**Print Patient / guardian Name**

\_\_\_\_\_

**Signature of Patient / guardian**

\_\_\_\_\_

**Date**