Alton PHYSIOTHERAPY & SPORTS CLINIC
4040 Palladium Way, Unit 5. Burlington, ON L7M 0V6
Tel: (905) 335-6100 Fax: (905) 335-6160

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

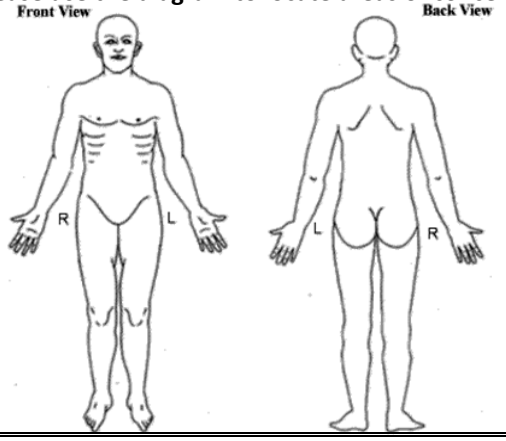
Reason(s) for consulting our office today: _____

When did this begin? _____ Has it occurred before? □ Yes □ No

How would you describe it? □ Achy □ Dull □ Numb □ Sharp

□ Stabbing □ Throbbing □ Tingling □ Other: _____

Please use the diagram to locate areas of concern



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: _____

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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:

Musculoskeletal
- ☐ headaches
- ☐ Jaw pain / TMJ
- ☐ Neck / shoulder
- ☐ Arm pain – Right/left
- ☐ Upper / mid back
- ☐ Low back / hip
- ☐ Leg pain – Right/left
- ☐ Knee pain – Right/left
- ☐ Tendonitis / bursitis
- ☐ Sprains / strains
- ☐ Osteoporosis
- ☐ **Arthritis**
- ☐ **"flat feet"**
- ☐ Other: _____

Cardiovascular
- ☐ High blood pressure
- ☐ Low blood pressure
- ☐ Heart disease
- ☐ Heart attack
- ☐ Pace maker/device
- ☐ Stroke / CVA
- ☐ **Varicose veins**
- ☐ Difficulty breathing
- ☐ Chronic cough
- ☐ Sinus problems
- ☐ Allergies
- ☐ Other: _____

Infection
- ☐ Herpes
- ☐ Hepatitis
- ☐ Plantar warts
- ☐ TB
- ☐ HIV / AIDS
- ☐ Other: _____

Miscellaneous
- ☐ Anxiety
- ☐ Depression
- ☐ Unexplained Weight loss
- ☐ **Restless Leg syndrome**

Nervous System
- ☐ Chronic pain
- ☐ Numbness / tingling
- ☐ Fatigue
- ☐ Insomnia
- ☐ Loss of sensation
- ☐ Other: _____

Skin
- ☐ Allergies
- ☐ Infections
- ☐ Rashes
- ☐ Wounds / scars
- ☐ Bruise easily
- ☐ Other: _____

Women
- ☐ Menstrual problems
- ☐ Gynaecological surgeries: _____
- ☐ Pregnant Due Date: _____
- ☐ Pregnant Due Date: _____
- ☐ Other: _____

Pathologies
- ☐ Liver
- ☐ Kidney – Right/Left
- ☐ Bladder
- ☐ Diabetes
- ☐ Cancer
- ☐ Epilepsy
- ☐ Vision loss
- ☐ Hearing loss
- ☐ **Dizziness/vertigo**
- ☐ Thyroid problem

Digestive System
- ☐ Constipation
- ☐ Irritable bowel syndr.
- ☐ Other: _____

☐ 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**