MEDICAL HISTORY FORM

For your information:

An accurate health history is important to ensure that it is safe for you to receive a massage treatment. if your health status changes in the future, please let me know. All information gathered for this session is confidential except as required or allowed by law or except to facilitate diagnosis (assessment) or treatment. You will be asked for written authorization for release of any information. Please complete both sides of this form.

Name: _____ Date: _____

Address: _____ Tel Res: _____

City: _____ PC: _____ Tel Bus: _____

Date of Birth: _____ Occupation: _____ What is your primary complaint? _____

Who referred you? _____ Their address? _____

Health History

Please indicate conditions you are experiencing, or have experienced.

Respiratory

- ☐ Chronic cough
- ☐ Shortness of breath
- ☐ Bronchitis
- ☐ Asthma
- ☐ Emphysema

Cardiovascular

- ☐ High blood pressure
- ☐ Low blood pressure
- ☐ CCHF
- ☐ Heart attack
- ☐ Phlebitis
- ☐ Stroke/CVA
- ☐ Pacemaker or similar device

Skin

- ☐ Skin conditions

Other Conditions

- ☐ Loss of sensation
- ☐ Diabetes (onset: _____)
- ☐ Allergies (eg anaphylaxis) or skin irritation
- ☐ Epilepsy
- ☐ Cancer
- ☐ Arthritis

Head/Neck

- ☐ Vision problems
- ☐ Vision loss
- ☐ Ear problems
- ☐ Hearing loss

Infections

- ☐ Hepatitis
- ☐ Skin conditions
- ☐ TB
- ☐ HIV

Women

- ☐ Pregnant (due: _____)

Soft Tissue Discomfort and its Nature

- ☐ Neck _____
- ☐ Low back _____
- ☐ Mid back _____
- ☐ Upper back _____
- ☐ Shoulders _____
- ☐ Arms _____
- ☐ Legs _____
- ☐ Knees _____
- ☐ Other _____

What is your general health status?

_____

_____

_____

_____

_____

Current Medication: _____

Condition it treats: _____

Surgery: _____ Date: _____

Nature: _____

Injury: _____ Date: _____

Nature: _____

Primary Care Physician: _____

Address: _____ Phone: _____

Present involvement in other Health Care: (eg Chiropractor)

☐ Yes ☐ No

If Yes, please specify: _____

_____

Other Medical Conditions: (eg digestive conditions, gynaecological conditions, hemophilia, etc)

_____

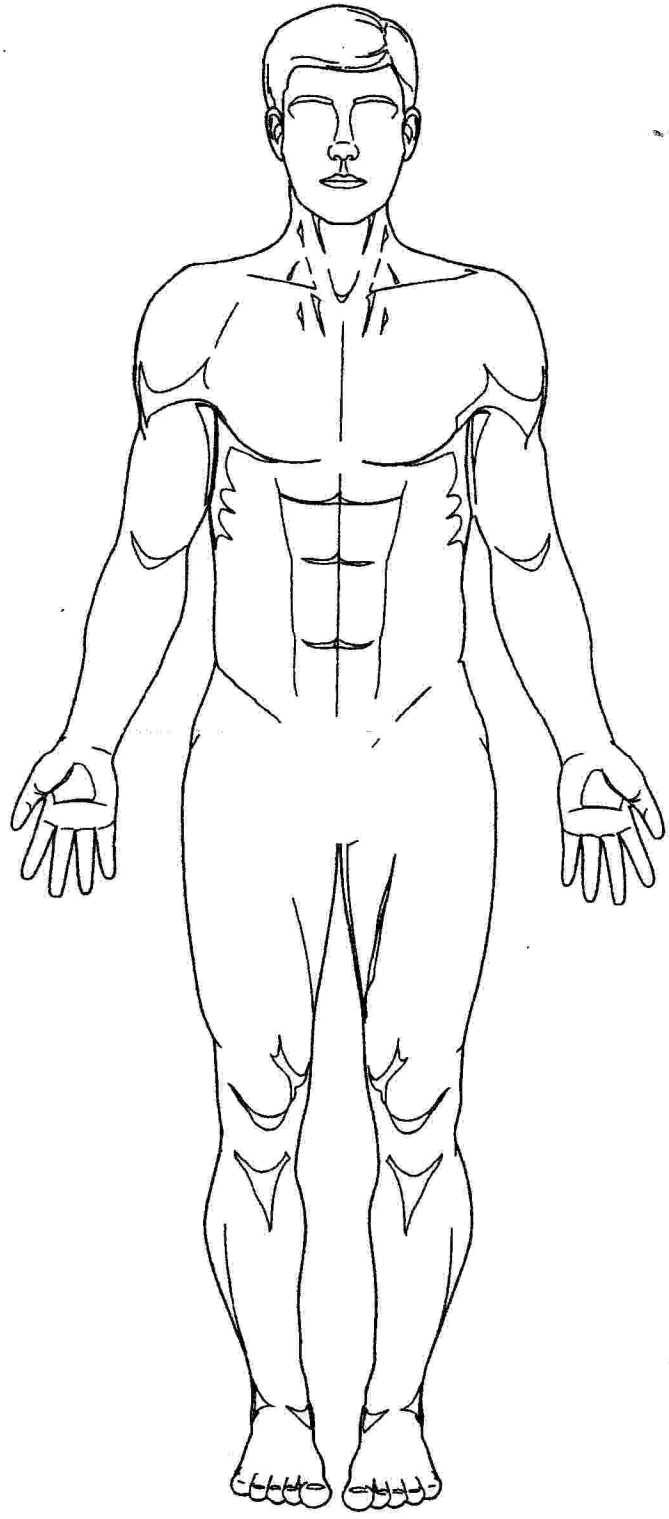
Of Special Note: (presence of internal pins, wires, artificial joints, special equipment)

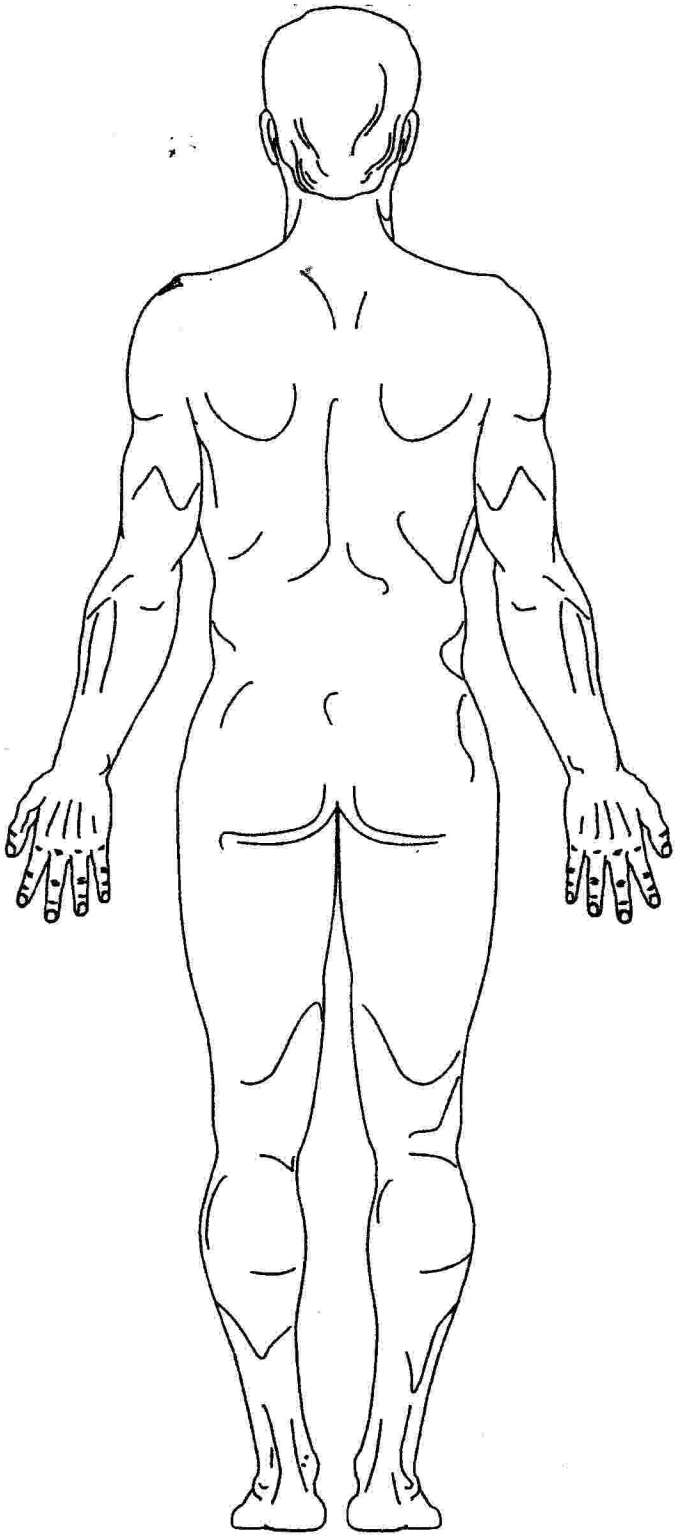
_____

This form is recognized by the College of Massage Therapists of Ontario to contain the elements necessary to ensure compliance with the Standards of Practice, 1996.

MEDICAL HISTORY FORM

Please shade in the areas where you feel pain or discomfort and colour in the areas where you feel pain.





I declare that the information on this Medical History Form is true to the best of my knowledge.

Name _____ Signature _____ Date _____